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CONTENTS

The Use of a Cholinergic Agent in Diagnosing Borderline Cardiac Disease
By I. E. Buff, M. D.

The Significance of Hematuria
By R. M. LeComte, M. D.

Pulmonary Function Studies in Bituminous Coal Miners
By Hurley L. Motley, M. D.

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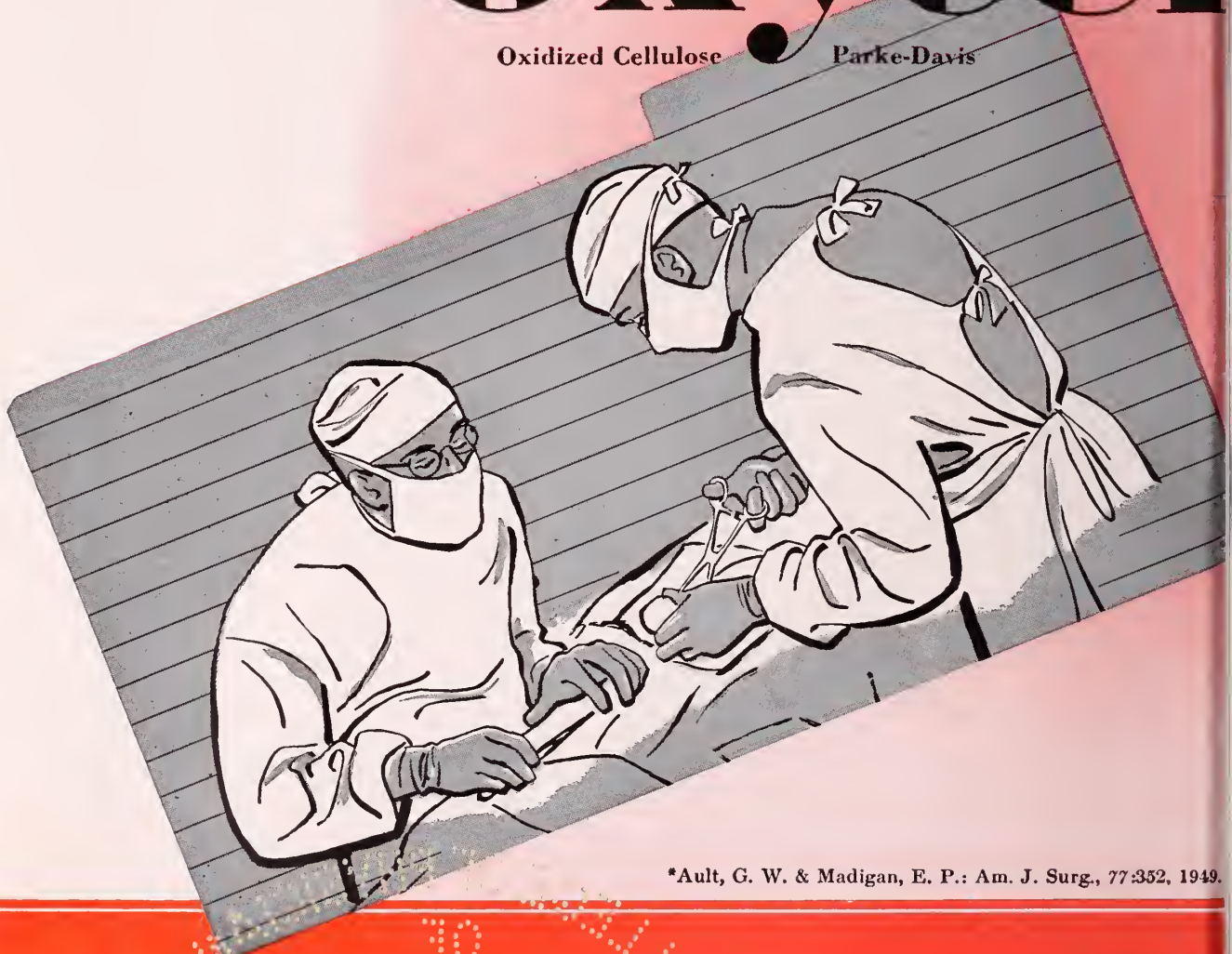

*Ault, G. W. & Madigan, E. P.: Am. J. Surg., 77:352, 1949.

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WALTER E. VEST, M. D.
955 Fourth Ave.
Huntington, W. Va.

Managing Editor and
Business Manager
MR. CHARLES LIVELY
Box 1031
Charleston 24, W. Va.

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Vol. XLVI JANUARY, 1950 No. 1

THE USE OF A CHOLINERGIC AGENT IN DIAGNOSING BORDERLINE CARDIAC DISEASE

By I. E. BUFF, M. D.,
Charleston, W. Va.

The comparatively recent introduction of electrocardiography into routine clinical practice has been accompanied by the rather common lack of a proper understanding of the tracings. This is true especially in the case of the general practitioner who has not had the opportunity of studying this technique intensively. An intelligent interpretation of an electrocardiogram requires not only a full knowledge of the patient's clinical history, but also a thorough understanding of all of the minor variations and deviations of the tracing from the so-called "normal" pattern. It is believed that there are in existence today many thousands of individuals who have been told they are suffering from cardiac disorders only because their electrocardiographic tracing did not fit into the textbook pattern of "normality." It is the purpose of this report to call attention to one set of such "abnormalities" which are really physiologic in character and which can be easily eliminated.

Tachycardias of certain origins can be easily differentiated and diagnosed by means of electrocardiography. For example, anyone with basic knowledge in this field can distinguish easily a case of paroxysmal auricular tachycardia from one of paroxysmal ventricular tachycardia.

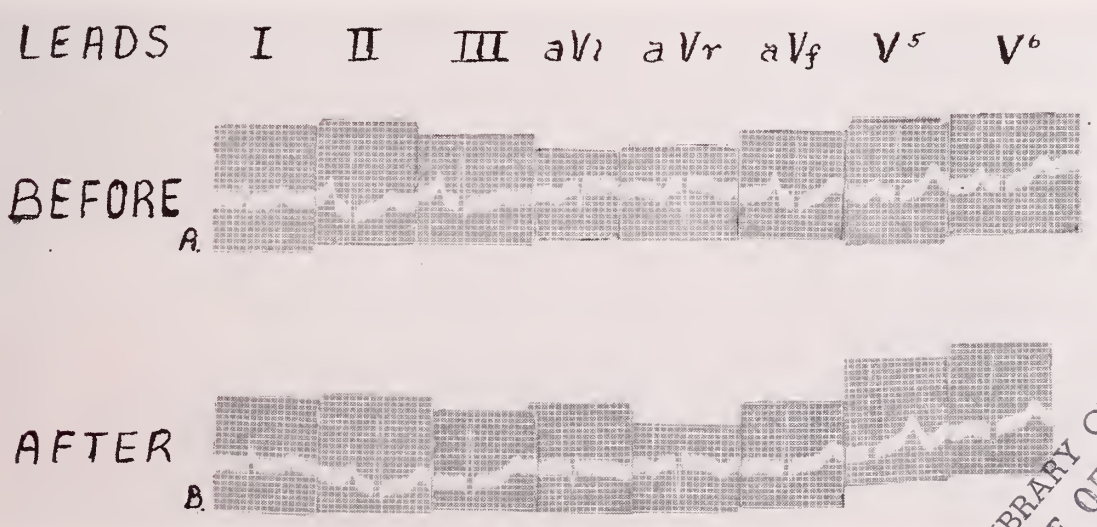

Fig. 1. Note the enlarged P waves disappear after Prostigmin.

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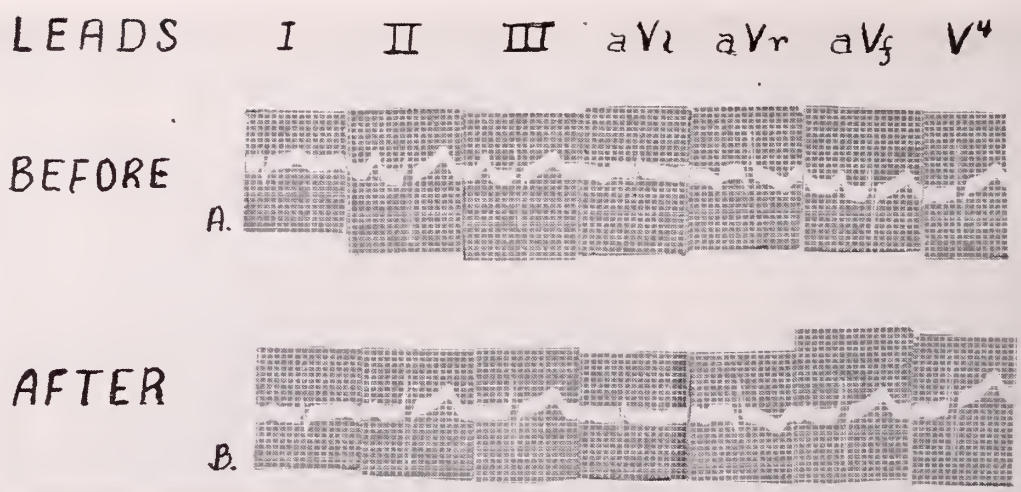

Fig. 2. The auricular waves become normal after Prostigmin.

Physiologic tachycardia, such as that frequently observed when an electrocardiogram is being taken for the first time, is also rather simple to diagnose. However, in the latter instance, certain "abnormalities" may be seen in the tracing which, to the inexperienced clinician, are at times misconstrued as evidence of myocardial damage. For example, the P waves may vary somewhat from the normal standard, or there may be a slight depression of the S-T segment. While it is true that such minor deviations from the normal may indicate cardiac damage, it is not true in every case, especially when tachycardia is present.

In our practice it has been customary for several years to use Prostigmin* in aborting attacks of supraventricular tachycardia. The value of this drug in this condition was first reported by Waldman and Moskowitz[1]. Since their publication in 1941, numerous others have appeared[2,3,4,5,6]. It is believed that Prostigmin decreases an abnormally high cardiac rate through the medium of vagal stimulation[7].

It was decided to use Prostigmin empirically in cases of simple sinus tachycardia with minor electrocardiographic changes to determine whether the drug would reduce the heart rate to normal and thereby possibly alter the electrocardiogram. This has been done in a series of approximately 60 cases. In each case the subcutaneous administration of 1.0 mg. Prostigmin Methylsulfate not only reduced the heart rate, but apparently was responsible for the disappearance of the electrocardiographic abnormalities noted on the pretreatment tracings.

*Brand of Neostigmine, U. S. P. (Hoffmann La Roche, Nutley, N. J.)

The following three case histories are representative:

Case 1.—C. P., male, aged 38 years. The patient complained of vague precordial pain unrelated to exertion. Physical examination of the heart revealed no abnormalities. An electrocardiogram (Fig. 1A) showed a cardiac rate of 94 per minute in standard leads and 112 in AV leads. The P-R interval was 0.16 seconds; P waves were enlarged; the S-T segment was depressed 1.0 mm. in leads II, III and aVf, and 0.5 mm. in leads V_5 and V_6. This could be interpreted as being indicative of myocardial damage, auricular hypertrophy and possibly early left ventricular hypertrophy (V_5 and V_6).

Because of the suspicion that these changes were physiologic and due to the moderate degree of tachycardia, a subcutaneous dose of 1.0 mg. Prostigmin Methylsulfate was given. Twenty minutes later another tracing was obtained (Fig. 1B). This revealed a cardiac rate of 75 per minute and no abnormalities whatsoever. A diagnosis of intercostal neuritis was made.

Case 2.—H. I. A., male, aged 24 years. The patient gave a history of having been diagnosed two years before as having rheumatic heart disease. His activity was sharply curtailed and a rather severe cardiac neurosis developed.

Physical examination revealed no gross abnormalities. An electrocardiographic tracing (Fig. 2A) demonstrated a cardiac rate of 100 per minute, the P-R interval was 0.21 seconds, and there were enlarged P waves in leads II, III and aVf. These changes could well be interpreted as being indicative of auricular hypertrophy with rheumatic heart disease.

The patient was given 0.5 mg. Prostigmin Methylsulfate subcutaneously and another tracing (Fig. 2B) obtained twenty minutes later. This revealed no changes in the P waves and a P-R interval of only 0.20 seconds, the upper limit of normal[8].

Case 3.—V. S., female, aged 74 years. The patient was seen for a routine physical check-up. There were no subjective symptoms. Physical examination revealed retinal changes, interpreted as being due to arteriosclerosis. Blood pressure was 180/94 mm. Hg., but the heart sounds were normal with no murmurs.

An electrocardiogram (Fig. 3A) revealed a heart rate of 100 per minute and a definite S-T depression in leads V_4 and V_5, especially in the latter. This could justifiably be interpreted as being indicative of left ventricular hypertrophy (secondary to the hypertension). After a subcutaneous dose of 1.0 mg. Prostigmin Methylsulfate a second tracing (Fig. 3B) revealed a cardiac rate of 83 per minute. The S-T depression in leads V_4 and V_5 had completely disappeared. The patient was diagnosed as having an essentially normal heart.

COMMENT

The three typical case histories are revealing in that they demonstrate that certain individuals with cardiac-like symptoms and a suspiciously abnormal electrocardiogram in the presence of tachycardia can be easily incorrectly diagnosed as having disease of the cardiovascular system. While this mistake may not be too serious in some cases, it may be a tragedy in others (Case 2). It is especially deplorable when one is dealing with a child or young adult, in either of which case the psychic consequences might be sufficiently grave as to lead to serious personality change.

An urgent plea is made that all such individuals be examined with great care and a second electrocardiographic tracing obtained following the administration of 1.0 mg. Prostigmin Methylsulfate if the first tracing reveals tachycardia. It is believed that this means a substantial number of patients who otherwise might be converted into cardiac cripples can be reassured that they possess an essentially normal cardiovascular system.

SUMMARY

1. Simple tachycardia can produce electrocardiographic changes which may be interpreted as being due to organic cardiac changes.

2. The subcutaneous administration of 1.0 mg. Prostigmin[r] Methylsulfate frequently reduces the heart rate and eliminates the electrocardiographic "abnormalities."

3. An urgent plea is made that in borderline cases a second electrocardiogram be obtained after the administration of Prostigmin Methylsulfate in order to avoid an incorrect diagnosis of cardiac disease which might otherwise produce cardiac cripples.

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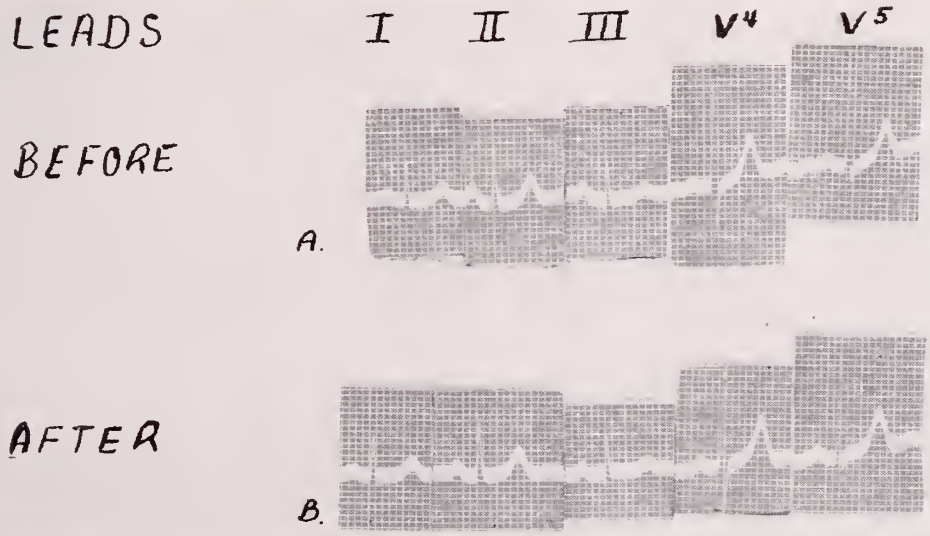

Fig. 3. The S-T depressions in V_4 and V_5 become less evident after Prostigmin.

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HYPOSENSITIZATION IN ALLERGY

The objectives in the treatment of an allergic patient are fourfold. First and foremost, the offending allergen should be avoided if possible and practical. Secondly, measures should be carried out to develop greater tolerance to histamine in the allergic patient. Thirdley, the patient should be given sound symptomatic treatment to minimize his discomfort. Fourthly, the patient should have the benefit of hyposensitization to those things in his environment which he finds impossible to avoid.

The importance of hyposensitization cannot be overemphasized, particularly in the young adult, since by such treatment alone can a simple seasonal allergic rhinitis be prevented from becoming a perennial, completely incapacitating asthma. It is particularly important that the young adult with asthma be given the benefit of hyposensitization when avoidance of the offending allergen is not practical, since by such measures asthma can usually be prevented from becoming wrose as the patient grows older.—Harold L. Neuenschwander, M. D., in Acuff Clinic Bulletin.

NEED FOR A HOBBY—AND A VACATION

The value of a hobby is beyond question. To many people the mere fact of having a piece of wood in a vise, a stamp collection or a plant in the garden, something which is absolutely theirs to destroy or bring to a thing of beauty or worth is an escape of priceless value.

An executive may be properly fed, amused and rested but if he is going to do really productive work in the year ahead he must have a vacation. The meaning of this word is a prolonged departure from one's usual routine and scene of action. It should be characterized by activities in which the elements of play and pleasure are stressed. All responsibility for the daily task are shed like a garment to permit the restoration of mental and physical vigour.

There is the ever-present question of how long the vacation should be. Usually the first week is spent in learning how to relax, the second week the vacationer is as relaxed as the well known rag, and the third week sees a return of the old zip and zing and an eagerness to return to his work. For the average executive under real pressure this cycle takes at least three weeks—F. M. Jones, M. D., in Ontario Med Rev.

THE SIGNIFICANCE OF HEMATURIA*

By R. M. LeCOMTE, M. D.,
Washington, D. C.

Hematuria is always a symptom, never a disease which is to be treated for itself alone. If blood appears in the urine either in large amount so that it can be readily recognized by the naked eye, or in smaller quantity so that it can be detected only by the microscope, the inference is clear that some difficulty is present which demands attention urgently. Examination should not be postponed because of inconvenience at the moment or because the bleeding may happen to have ceased after one or more episodes. The location and nature of the basic lesion must always be sought out and determined promptly so that rational and adequate treatment may be administered.

Hematuria has many variable and misleading characteristics. It may come on suddenly without any prodrome or associated symptom or sign, or it may appear to be just an incident in the course of some disease that is already evident. It may cease suddenly without any particular endeavor having been made to control it, or it may persist for long periods despite earnest, careful and persistent efforts at diagnosis and treatment. It may be diagnosed easily, or it may defy measures undertaken to determine its source of origin and its cause. It may vary in amount from a few red cells in a centrifuged specimen to situations in which all of the material voided seems to be blood. The blood loss may be minimal, or it may be so great as to exsanguinate the patient and cause death from acute anemia in a few hours or days. The shade of the blood passed may vary from bright red to dark brown or even black, depending on the amount of blood present and the length of time that has elapsed between the time it was shed and the time it was voided; the darker the blood, the safer the inference that a considerable period has elapsed between the shedding of the blood and the voiding, likewise that urinary retention of one sort or another exists. Clots may be present and, if so, these indicate that considerable blood has been shed rather rapidly into some cavity, normal or pathologic, in which they have been retained long enough for clotting to have occurred.

Thin, elongated, worm-like clots generally originate above the bladder and are then really casts of the ureter. Clots formed in the bladder are generaly large and irregular in shape. But,

*Presented before the 82nd annual meeting of the West Virginia State Medical Association, at White Sulphur Springs, August 6, 1949.

bleeding in large amount may occur in the kidney or ureter and coagulation take place only after the bladder has been reached. Clots may fill the bladder and cause retention of urine.

Hematuria tends to be intermittent and this characteristic often is the reason for complacency and for delay in initiating investigations to determine its source and cause. The patient who is startled by the sudden appearance of the red color of the stream that he passes may be lulled into a false sense of security when he finds that the next voiding is perfectly clear The physician may be thrilled with satisfaction when the bleeding ceases suddenly after he has prescribed some remedy even though it was based on grounds that were completely empiric. Very often subsequent developments show that the good result was quite accidental. These and many other less striking characteristics make hematuria an interesting and alluring problem; it may, on occasion, become an exasperating one. Whatever feature or features it may present, it always has a grave implication and must always be considered to be of serious import until its source has been accurately determined and the lesion responsible for it thoroughly worked out and found to be relatively innocuous, if such a possibility may be said, in fact, to exist.

The causes of hematuria are so numerous and of such diverse nature that they defy a concise, thoroughgoing and, at the same time, satisfying classification. Hematuria may spring from any lesion, large or small, of almost any character anywhere in the urinary tract. In some serious lesions, notably tumor and stone, hermaturia may be the only symptom; in many, it is the dominant sign, especially as an initial one.

A fairly satisfactory way to outline the etiology so that it will have some diagnostic worth is to enter the causes under general and local headings, and subdivide each of these under subheadings, depending on whether or not other readily determinable symptoms or signs are present. The degenerative types of kidney disease, the nephroses and glomerular nephritis, and the renal changes due to or accompanying hypertension, occupy a middle ground between the two main groups stated.

The general causes include infectious diseases such as scarlet fever and pneumonia; some parasitic infestations such as hookworm disease; blood dyscrasias such as hemophilia, purpura and the leukemias; the crystallurias; toxic causes such as dicumarol, heparin and sulfonamide over-action and the effects of exposure to certain analine dyes; a few avitaminoses such as scurvy, and other less clearly defined difficulties such as Hodgkin's disease. In these diseases, hematuria is only part of a more or less wide spread disorder which involves the urinary tissues as an incidental rather than a dominant effect. Ordinarily they can be determined rather readily from the history and on adequate clinical and laboratory examinations. In each of them, however, an independent local lesion may be the cause of the hematuria, and a searching urologic study may be required for its detection. This fact must be kept in mind constantly. In some of these borderline or general diseases, the prognosis may be so poor that the prospect of benefit does not warrant the hazard of a urologic study; in others, hematuria is the initial symptom which draws attention to the general disease and urologic investigation is only the first step in the establishment of the presence of the basic extra-urinary systemic disorder.

Any local lesion of the urinary tract which by experience and custom has come to be considered as having a surgical import may, at one time or another in its course, result in hematuria. In only a few is hematuria often found to be the predominant or presenting symptom. Frequent causes are hernia, neoplasm and stone, less often uncomplicated urinary infections. Hematuria is, of course, a significant finding in traumatic lesions either accidental or instrumental and it should be looked for carefully and repeatedly in cases in which injury is known or suspected. Hematuria is not unusual in that group of diseases, such as prostatism and hydronephrosis, in which obstruction and retention of urine are often significant and dominant features of the pathology.

Establishing the presence of hematuria usually is a simple matter. The male may note a blood-stained urethral discharge. More often he discovers the condition by seeing blood in the stream as the urine is passed or in the vessel into which it has been voided. This discovery usually brings him to the physician promptly. The female may not identify the source of the blood so readily. She may confuse hematuria with rectal bleeding, or she may mistake it for bleeding from the vagina and ascribe it to irregular menses or to metrorrhagia.

Certain sources of error must be mentioned, but with microscopic tests now so readily available, they are seldom persisted in for long. Uratic sediment may take on a red color, and drugs such as rhubarb, senna and sulfonal may impart a red color to the urine. In instances of suspected drug addiction and in cases of possible malingering in males, the patient must be made

to void in the presence of the examiner. In females catheterization is always necessary to determine accurately the source of the blood. In both sexes and at all times microscopic examination of the urine must be made both to establish the presence of red blood cells and to discover, if present, any other formed elements such as pus cells, bacteria and perhaps fragments of tumor cells. If an individual gives a history of hematuria but the symptom is not found on careful examination, it is perhaps better to assume that the history is correct and thus either to proceed with the examination or have him return when blood is present than to pass off the symptom as nonexistent, inconsequential or incorrect. As was noted heretofore, hematuria tends to be intermittent and it is quite possible for it to be present at one time and absent at another, even though the patient has a serious lesion such as a kidney or bladder tumor or stone.

Concomitant or associated symptoms may indicate the position of the local lesion responsible for hematuria. By long odds the most important of these is pain. In clinical urology, it is almost axiomatic that painless hematuria signifies bladder tumor or worse. If pain is present, the responsible lesion is apt to be less serious, at least in so far as eventual recovery and life expectancy are concerned.

Lumbar pain generally signifies obstruction to the outflow of urine from the renal pelvis, abdominal colic a ureteral obstruction, and hypogastric pain vesical distention. Stone, of course, always looms largely as a probable cause of renal pain and ureteral colic, and always must be thought of in the presence of these symptoms, especially when associated with hematuria. If pain is present, the problem then becomes one of determining the nature and extent of the basic lesion together with those of whatever complications may have developed from it. Ordinarily these are easily run down in the subsequent urologic and urographic studies.

Symptoms of bladder irritation (painful, frequent urination) may have various meanings. They may be reflex from renal diseases or from ureteral stone. In the female, painful, frequent urination usually signfies infection or inflammation; in the male, it may mean infection or, at the prostatic age, obstruction with retention of urine, generally the result of prostatic enlargement. These symptoms are easily amplified and their cause determined by a search for pus and blood in the urine, by estimation of the residual urine, by demonstration of a distended bladder or by detection of prostatic disease on rectal examination.

Painless hematuria is such a deceptive symptom that it deserves a homily or preachment on its importance. Urinary infections, stones and obstructions, by their very nature, most often give pain or irritative symptoms before they have progressed to any great extent; hemorrhage may occur in these cases only after the conditions are rather well advanced and only after well marked vascular changes have been produced by them. On the other hand, neoplasms or tumors, especially malignant ones, because of their infiltrative and invasive nature, often erode into blood vessels and cause hemorrhage before they are large enough to produce obstruction or before they have brought about enough necrosis to favor bacterial invasion and cause infection. The deduction to be drawn from this is that the burden of the physician is greater in instances of painless hematuria than it is if hematuria is associated with pain and other symptoms. Patients and physicians are apt to discount the importance of any symptoms not accompanied by pain. This should not be. In cases of neoplasm, especially when malignant, pain is apt to be a late symptom rather than an early one, occuring only after complications have developed. Cancer of an internal organ becomes evident not so much by itself as by the complications that it engenders. Oftentimes bleeding is the first sign; cure is obtained only by early operation; if cure is to be effected, this first sign must be followed up, a diagnosis made, and proper treatment initiated as soon as possible.

Once suspected on reasonable grounds or established by examination, measures to determine the exact source of bleeding and the nature of the lesion responsible for it should be set in motion. The first step is the taking of a history, having especial regard to any trauma that may have been sustained, to associated symptoms that may have developed and to any pain that may have occurred; an inquiry as the character, intensity and location of pain should be made. The second step is a physical examination which must include a urinalysis, in particular a microscopic study for pus and bacteria, palpation of the flanks for tenderness and masses, and a blood pressure reading. A vaginal examination should be done in the case of every female and a search for residual urine and rectal examination made in the case of every male.

If gross bleeding is going on, cystoscopy should be done at once unless there is evident contraindication to it. By cystoscopy the source

of the bleeding may be determined more accurately than by any other method. This information is of great help in intelligently orienting subsequent studies to determine the cause; the advantage is so great that an alert urologist on discovering gross hematuria in an office patient, is apt to consider the case an emergency, to set aside other work, and to perform cystoscopy at once. By cystoscopy, the bleeding point (or the reason for the bleeding such as tumor) may be seen in the bladder or posterior urethra. Renal or ureteral bleeding can be determined with certainty only by viewing blood or bloody urine as it issues from one or both of the ureteral orifices. Slight trauma with bleeding almost invariably occurs in passing ureteral catheters so that urinary specimens so taken are worthless in so far as determining whether or not nontraumatic bleeding is occurring.

There are many contraindications to immediate cystoscopy but absolute ones are few and readily detected. Commonly observed ones are evident signs of uremia, severe urinary or other infection, a large amount of residual urine due to an enlarged prostate, marked lumbar tenderness and large palpable lumbar masses, either unilateral or bilateral. All of these will be evident if a careful physical examination has been made. If there is any question as to the safety of the manipulation, cystoscopy should be postponed until other examinations such as blood chemistry estimations and x-ray studies have shown that it will be harmless and worthwhile.

If the bleeding has ceased when the patient first appears, cystoscopy may be done at once or it may be postponed until x-ray and urographic studies have been made. A well executed and intelligently interpreted excretory urogram may, in itself, show up the responsible lesion clearly and thus solve the problem of diagnosis.

Time and space do not permit a review of the many urologic lesions that may bleed and which may be well shown by roentgenographic studies. They are well known to roentgenologists and urologists, and are well covered in textbooks on these subjects. If the scout films and intravenous urogram, are at all imperfect or the diagnostic data to be read from them in any way questionable, they may be repeated or, better still, retrograde pyelography undertaken. In many instances this will have to be done for confirmation or elaboration. In every instance of hematuria cystoscopy will have to be done sooner or later to exclude bladder tumor. It should not be delayed overlong. The need for checking on or amplifying inconclusive pyelographic findings with bacteriologic, functional and cytologic data gives an opportunity for carrying it out.

In most instances, the data accumulated by these examinations will serve to demonstrate the source and cause of the hematuria and to furnish clear indications for treatment. In others, no lesion can be found. The general causes then must be checked. The patient should be examined by a skilled internist.

If no lesion is demonstrated and the bleeding ceases completely, the patient should be kept under observation and the urine examined for blood from time to time. If the bleeding reappears at any time, cystoscopy at least should be done to exclude bladder tumor. If the source of the blood on reexamination is found to be from a ureteral orifice, urographic studies should be repeated. If the bleeding continues, reexaminations should be urged at reasonable intervals. A consultation will always be helpful even if no satisfactory diagnosis is reached. The patient may drift. Eventually, if enough time and effort are expended and enough cooperation is secured, the problem will be solved. This may require not days or weeks but, if necessary, months or even years.

The prognosis will then depend on the seriousness of the primary lesion disclosed and on the extent to which it has developed before breaking through with enough evidence to bring it into a detectable stage.

Essential or idiopathic hematuria is a type that is remarkable because of its almost completely negative aspects. Blood appears in the urine in greater or lesser amount and remains the sole symptom and sign. It may persist for long periods, occur intermittently for no apparent reason, or it may clear up spontaneously in a short time. The laboratory and clinical examinations are negative. The urine is free from pus and from bacteria both on smear and culture and on animal innoculation. On cystoscopy, a bloody jet is seen issuing from one or from both of the ureteral orifices; in functional studies the two kidneys balance up; x-ray and pyelographic studies show only insignificant abnormalities. The bleeding may cease after ureteral catherization or after the injection of silver nitrate solution into the kidney pelvis, or it may persist despite such treatment for an indefinite period. If the responsible kidney is explored its exterior is found to be normal; if it is removed, perhaps of excessive bleeding, only minor lesions are detectable. Eventually, perhaps only after years, some lesion such as stone, tuberculosis, neoplasm or a degenerative nephritis may de-

velop into a detectable stage. Idiopathic hematuria is less frequently diagnosed as examinations are made more frequently and more thoroughly.

The ideal treatment of hematuria is the cure of the basic lesion. This, of course, depends on an accurate diagnosis and on the presence of a curable lesion.

In some rare instances the clinical evidence is negative except for the bleeding, and x-ray examinations fail to show more than indefinite bladder pathology which may very well be due to retained clots. The bleeding continues to be so brisk that the bladder contents are quickly clouded and cystoscopic vision is greatly limited. Not even the source of the bleeding can be determined. The patient then must be put at rest in bed and an indwelling catheter placed. This may influence the situation favorably so that the bleeding ceases or becomes minimal in amount and adequate vision is possible.

Irrigations with styptic solutions such as zinc sulfate, tannic acid and adrenalin have been of very little help in my experience; nor have I found coagulants such as vitamin K, calcium, ergot and coagulen to be worthwhile. However, they may be given a trial. If the bleeding fails to stop or if the bladder fills repeatedly with large clots so that frequent instrumental evacuation is required, the situation may worsen so that life is threatened by acute hemorrhage.

Before the situation has become so critical that an acute emergency exists, the urologist must admit diagnostic defeat and endeavor to make the diagnosis by operative means and to save life by checking hemorrhage. Under the conditions outlined, the probabilities are that the blood springs from either a bladder or a renal neoplasm. The bladder should be opened. If neither tumor nor bleeding bladder lesion is found the ureteral orfices should be observed. Blood may be issuing from one of them. Generally, this means a renal or ureteral neoplasm. If the condition of the patient permits, and exploratory renal operation may be done at once and the kidney and ureter explored; otherwise, operation may be done if the patient improves enough to make it safe. These conditions are rare and are mentioned here only to render complete coverage of the subject. They do occur, and one should be prepared to recognize and meet them when they appear.

CONTROL OF CHRONIC DIARRHEA

Calcium gluconate in 1 gram tablets (two chewed and washed down with water) taken three hours after meals is often effective in the control of a chronic diarrhea. Why is not understood.—J. F. in Ohio State Med. J.

PULMONARY FUNCTION STUDIES IN BITUMINOUS COAL MINERS[1, 2, 3]

By HURLEY L. MOTLEY, M. D.,
Philadelphia, Pa.

Measurements of ventilation, emphysema and the respiratory gas exchange have been obtained in bituminous coal miners with anthracosilicosis. These findings have been compared with previous studies made on anthracosilicotic anthracite coal miners.[1,2] It was of interest to note whether any significant detectable difference of pulmonary function occurred in the two groups. A comparison of the roentgenological findings with the pulmonary function measurements was of use in correlating more accurately the nature of the breathing impairment. The discrepancy between roentgenological findings and pulmonary function studies is well recognized at the present time, however as yet, in disability evalution the roentgenological findings usually take precedence. As previously pointed out[3] physiological measurements of pulmonary function do not diagnose the disease, for which purpose a good history, physical examination and radiological examination are still necessary, but the information obtained from function studies permits a better evaluation of the disability present.

METHODS

The physiological measurements used in evaluating pulmonary function appear in table 1. These tests for the evaluation of pulmonary function have been adapted in general from the plan of investigation followed by Cournand, Richards and their co-workers.[4,5] The tests will be commented on very briefly here, more detailed descriptions appear elsewhere.[1,2,4,5,6] Maximal breathing capacity, a measurement of the maximal amount of air which can be moved in and out of the lungs in a given unit of time, was measured by a large modified Benedict-Roth metabolism apparatus.[1] The predicted values for maximal breathing capacity, vital capacity, residual air and total lung volume were calculated from the height, weight, age and sex of the patient.[4,5] Residual air was measured by the oxygen open circuit quantitative method[6] and duplicate checks were obtained within 100 cc. The oxygen uptake and carbon dioxide output of the air breathed were determined using a Scholander gas analyzer.[7] All resting measurements were in dupli-

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cate. The total minute ventilation was divided by the respiratory rate, obtained from a kymograph record, to determine the average tidal air. The effective tidal air was calculated from the mean partial pressure of carbon dioxide in the alveoli and in the expired air.[2] Arterial blood was obtained from the brachial artery both at rest and immediately after exercise, an indwelling Cournand type needle being used for the purpose. The arterial oxygen content and capacity and the carbon dioxide content were determined on the Van Slyke-Neill apparatus[8,9] and the percent oxygen saturation was calculated by dividing the oxygen content by the oxygen capacity after corrections had been made for the amount of oxygen dissolved in the plasma. The tension of oxygen and carbon dioxide in mm. Hg. was obtained directly on arterial blood using the method of Riley.[10] The arterial blood pH was determined directly by a glass electrode. The indirect method was used for calculating alveolar oxygen partial pressure (pO_2), where the arterial pCO_2 and alveolar pCO_2 were assumed to be the same.[11] This indirect method for calculating the alveolar pO_2 was satisfactory in the anthracosilicosis cases since consistent results could be obtained in repeated determinations even after prolonged periods of time.

Table 1

MEASUREMENTS USED IN EVALUATION OF PULMONARY FUNCTION

Measurements	*Average Normal Values for Men*
1. Maximal Breathing Capacity (MBC)	100-150 liters/min.
2. Vital Capacity (VC)	3500-5000 cc.
3. Residual Air	1000-1500 cc.
4. Ventilation Volume, per minute, per sq. meter (Sq.M.) body surface area (B. S. A.)	
A. Rest	2.6-3.8 liters
B. Exercise	8.0-10.5 liters
5. Oxygen Uptake from Air Breathed	
A. Rest	4.0-5.0% (40-50 cc./liter)
B. Exercise	5.0-6.0% (50-60 cc./liter)
6. Carbon Dioxide Addition to Air Breathed	
A. Rest	3.2-4.0% (32-40 cc./liter)
B. Exercise	3.4-4.2% (34-42 cc./liter)
7. Arterial Blood	
A. Carbon Dioxide Content (Van Slyke Method)	
(1) Rest	48.5 Vol. %
(2) Exercise	42.5 Vol. %
B. Oxygen Content (Van Slyke Method)	
(1) Rest	19.0 Vol. %
(2) Exercise	19.2 Vol. %
C. Hemoglobin Saturation	
(1) Rest	96+%
(2) Exercise	96+%
D. Mean Resting Tensions (Riley Method)	
(1) Oxygen (pO_2)	95 mm. Hg.
(2) Carbon Dioxide (pCO_2)	40 mm. Hg.
8. Dyspnea following Mild Exercise (Exercise—30 step ups in one minute on stool 20 cm. high)	60 seconds

The difference in mean oxygen partial pressure between the inspired air and the alveolus is referred to as the *aeration gradient*, and the difference in mean oxygen partial pressure between the alveolus and the arterial blood is designated as *transfer gradient*. Transfer gradient has been used since it deals with the movement of oxygen from the gaseous state in the alveolus to either combination with hemoglobin or solution in the blood plasma. An increased transfer gradient designates changes in the alveolar-arterial gradient from all cases including diffusion difficulty with an increased resistance in the pulmonary membrane. This latter has been found to be of minor significance in chronic pulmonary disease associated with silica inhalation.[12, 13]

MATERIAL FOR STUDY

Physiological measurements (table 1) have been obtained on 56 bituminous coal miners with a history of prolonged exposure inside the mines (average 32 years). These miners were sent to the Barton Memorial Division of Jefferson Medical College Hospital for pulmonary function studies by arrangement with Dr. R. R. Sayers, Washington, D. C. The subjects studied were representatives from bituminous coal mines in the states of: W. Va., Penna., Ky., Va., Ala., Ohio, Okla., Ill., Md., Ind., and the province of Nova Scotia; however, the largest number, 26, came from W. Va. There was no selection of the group of subjects by the laboratory staff except that a few cases with proven pulmonary tuberculosis and cardiac decompensation were omitted from the study. The symptoms of these patients were similar to those previously reported.[14]

RESULTS

The 56 cases of anthracosilicosis in bituminous miners were divided in five groups according to the degree of emphysema present, table 2. All of the physiological measurements have been classified in table 3 according to the degree of emphysema present as based on quantitative measurements of residual air. The degree of pulmonary emphysema was correlated with the age of the miner, figure 1, and further compared with similar measurements in anthracite miners previously reported.[1,3] All degrees of emphysema were found in all age groups in the bituminous miners, just as in the anthracite miners, figure 1, tables 3 and 4. The degree of emphysema was

Table 3

MEASUREMENTS ON VENTILATION, EMPHYSEMA AND THE RESPIRATORY GAS EXCHANGE IN FIFTY-SIX BITUMINOUS MINERS

DEGREE OF EMPHYSEMA	GROUP I None		GROUP II Slight		GROUP III Moderate		GROUP IV Advanced		GROUP V Far Advanced	
	Average	*Range*	*Average*	*Range*	*Average*	*Range*	*Average*	*Range*	*Average*	*Range*
1. Number of Cases	5		17		14		16		4	
2. Age in Years	45	(35-57)	51	(43-64)	53	(41-62)	55	(45-68)	51	(48-54)
3. Inside Mine Exposure, Years	28	(16-40)	30	(19-47)	33	(21-42)	35	(20-48)	31	(25-35)
4. B. S. A., Sq. M.	1.87	(1.76-2.00)	1.82	(1.54-2.05)	1.79	(1.64-1.96)	1.73	(1.54-1.99)	1.71	(1.60-1.83)
5. Maximal Breathing Capacity										
Observed, L. per min.	105	(61-133)	92	(43-154)	77	(40-106)	45	(27-75)	22	(20-25)
Percent of Normal Predicted Value	89.4	(53-100)	86	(46-100)	74	(36-97)	46	(30-79)	22	(19-24)
6. Vital Capacity										
Observed, cc.	3700	(3200-4250)	3870	(2980-4840)	3380	(2620-4400)	2450	(1500-4160)	1816	(1650-2050)
Percent of Normal Predicted Value	86.5	(71-100)	90.8	(68-100)	80.0	(65-100)	57	(33-87)	44	(38-52)
7. Residual Air										
Observed, cc.	1140	(840-1380)	1690	(1270-2300)	2210	(1525-3205)	2540	(1300-4340)	3150	(2860-3680)
Percent of Total Lung Volume	23.3	(20.9-24.6)	30.4	(26.4-33.6)	39.4	(35.8-44.9)	50.8	(45.6-54.5)	63.8	(60.0-68.5)
8. Arterial Blood:										
A. CO_2 Content — Vol. Percent										
Rest	46.56	(44.5-47.9)	46.00	(41.4-50.8)	47.00	(43.4-51.6)	49.61	(43.90-59.35)	52.54	(50.25-55.15)
Exercise	42.43	(40.5-44.8)	42.90	(35.8-48.7)	44.90	(39.4-49.4)	47.74	(41.40-58.60)	51.17	(48.50-52.25)
B. O_2 Content — Vol. Percent										
Rest	19.22	(18.4-20.0)	18.70	(16.60-20.28)	18.28	(16.01-21.20)	17.09	(15.04-20.90)	18.21	(18.04-18.49)
Exercise	20.42	(19.6-21.3)	19.74	(17.30-21.36)	17.80	(16.00-21.47)	17.56	(13.90-20.12)	17.44	(16.94-17.70)
C. Hemoglobin — Percent Saturation (O_2)										
Rest	95.5	(93.5-96.8)	94.1	(89.5-96.8)	95.0	(91.5-100)	90.5	(82.7-94.4)	93.7	(86.4-96.4)
Exercise	95.5	(94.5-98.9)	94.0	(87.7-98.8)	93.2	(82.5-97.6)	87.2	(67.6-98.0)	84.7	(82.6-85.5)
D. Mean Resting Tensions — mm. Hg.										
pCO_2	44	(40-47)	45	(36-54)	44	(37-54)	48	(36-66)	54	(47-58)
pO_2	84	(80-88)	78	(61-99)	79	(67-97)	70	(44-89)	66	(55-83)
E. pHs										
Rest	7.43	(7.41-7.44)	7.45	(7.38-7.49)	7.44	(7.40-7.49)	7.43	(7.40-7.47)	7.40	(7.39-7.42)
Exercise	7.38	(7.37-7.41)	7.41	(7.33-7.38)	7.41	(7.36-7.45)	7.39	(7.36-7.49)	7.36	(7.34-7.37)
9. Resting Alveolar pO_2 — mm. Hg.	94	(90-100)	94	(74-109)	95	(85-104)	91	(66-107)	79	(73-85)
10. Resting Oxygen Gradients — mm. Hg.										
Aeration	53	(50-58)	53	(38-72)	52	(41-65)	57	(40-77)	70	(65-78)
Transfer	12	(6-18)	16	(2-40)	16	(4-25)	21	(8-39)	13	(2-19)
11. Air Breathed										
A. Ventilation — L. per min., per Sq. M. B. S. A.										
Rest	4.26	(3.32-6.66)	4.23	(3.51-5.70)	4.32	(3.62-5.50)	4.52	(3.36-5.17)	4.21	(3.86-5.12)
Exercise	12.64	(8.92-16.05)	12.00	(8.75-18.8)	13.04	(8.58-16.38)	11.39	(7.90-14.3)	9.73	(9.65-9.90)
B. Percent CO_2 Added										
Rest	2.60	(2.21-2.83)	2.53	(2.09-3.26)	2.54	(1.86-3.32)	2.49	(2.15-2.91)	2.58	(2.34-2.77)
Exercise	3.10	(2.59-3.46)	2.89	(2.29-3.79)	2.93	(2.32-4.03)	2.64	(2.04-3.76)	2.80	(2.43-2.94)
C. Percent O_2 Removed										
Rest	3.33	(2.90-3.74)	3.30	(2.36-4.25)	3.22	(2.07-3.94)	3.10	(2.56-3.72)	3.26	(2.35-3.58)
Exercise	4.44	(3.62-4.91)	3.60	(3.00-5.37)	3.99	(2.73-5.14)	3.57	(2.71-4.82)	3.70	(3.32-4.01)
D. Oxygen Uptake — cc. per min., per Sq. M. B. S. A.										
Rest	142	(122-193)	138	(109-173)	137	(114-163)	139	(125-156)	144	(136-157)
Exercise	553	(438-637)	504	(369-644)	508	(284-731)	402	(255-520)	359	(328-389)
E. Resting Tidal Air										
Observed, cc.	443	(368-553)	436	(306-645)	441	(259-650)	478	(276-678)	382	(367-412)
Percent Effective	62	(59-69)	57	(46-65)	58	(46-77)	53	(44-64)	52	(48-55)
12. Dyspnea After Exercise										
Sec.	129	(102-158)	132	(65-302)	133	(50-244)	139	(90-228)	185	(165-194)

insignificant in 31% of the anthracite miners and 39% of the bituminous miners, while an advanced or far advanced degree of emphysema was present in 40% of the anthracite miners and 36% of the bituminous miners. Although the number of bituminous miners studied is much smaller than the anthracite group, the findings are similar.

Table 2

CLASSIFICATION OF PULMONARY EMPHYSEMA

1. Measurements Used — Example
   - A. Vital Capacity ... (4500 cc.)
   - B. Residual Air ... (1500 cc.)
   - C. Total Lung Volume ... (6000 cc.)
   - D. Residual Air Percent of Total Lung Volume ... (25.0)
2. Degree of Emphysema Based on the Residual Air Percentage of Total Lung Volume by Groups.

A. Group I.	None	25% or less	Degree
B. Group II.	Slight	25-35%	Insignificant
C. Group III.	Moderate	35-45%	Degree
D. Group IV.	Advanced	45-55%	Significant
E. Group V.	Far Advanced	55% or above	

3. The above classification of emphysema based on quantitative measurements was used in grouping all cases for study and analysis of the data obtained.

Correlation of vital capacity and the degree of emphysema, figure 2, reveals that in general if vital capacity decreases the degree of emphysema increases, and in a manner similar to that noted for anthracite miners.[1] As a single measurement vital capacity alone was unsatisfactory in evaluating pulmonary function because of the wide individual variations and the poor correlation with the degree of emphysema.

Table 4

COMPARISON OF THE DEGREE OF PULMONARY EMPHYSEMA IN ANTHRACITE AND BITUMINOUS MINERS

Degree of Emphysema	*Bituminous Miners* No. Cases	Percentage	*Anthracite Miners* No. Cases	Percentage
None	5	8.92	21	9.72
Slight	17	30.36	47	21.76
Moderate	14	25.00	60	27.78
Advanced	16	28.58	41	18.98
Far Advanced	4	7.14	47	21.76
Total No.	56		216	

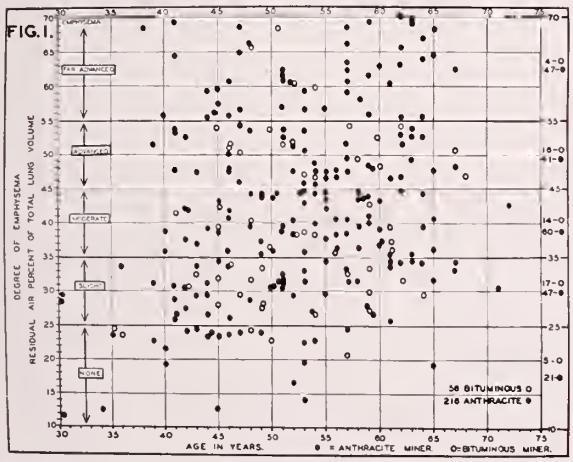

Fig. 1. Correlation of age in years with the degree of pulmonary emphysema. All degrees of emphysema occur in all age groups, both in bituminous and anthracite miners. Each dot represents one case. Note that over one third of all cases do not have a significant degree of pulmonary emphysema (residual air less than 35% of total lung volume).

The comparison of maximal breathing capacity (MBC) and the degree of emphysema showed that the decrease in MBC in bituminous miners was similar to that of anthracite miners,[1] figure 3. In general, if the MBC is less than 40 liters per minute the degree of emphysema is significant and insignificant if the MBC is over 100 liters per minute, figure 3. When the average residual air, vital capacity and MBC measurements from the five groups, classified according to the degree of emphysema, were studied an excellent correlation was noted, namely: as the residual air increased the vital capacity and MBC decreased, and the MBC decreased more in proportion than the vital capacity, a finding similar to that in the anthracite group.[1,3]

The average arterial blood oxygen content varied from 16 to 21 volumes percent in the five groups regardless of the degree of emphysema, table 3. As was noted in the anthracite miners,[2] even in patients with a far advanced degree of emphysema polycythemia or increased hemoglobin was rare. The carbon dioxide content rose progressively in the group of patients with a significant degree of pulmonary emphysema, table 3. The decrease in carbon dioxide content with exercise was slight in the advanced and far advanced groups while in the two groups without a significant degree of emphysema the decrease in carbon dioxide content was much more marked.

The arterial blood oxygen saturation both at rest and immediately after exercise was correlated with the degree of pulmonary emphysema, table 3. At rest the arterial oxygen saturation for the most part varied from 90 to 100 percent, there being no correlation with the degree of emphysema. However, the exercise arterial oxygen saturation data were different in the three groups with a significant degree of pulmonary emphysema. In general the more marked the emphysema, the greater the decrease in oxygen saturation with exercise, a finding also made in anthracite miners.[2] In the patients with the most advanced emphysema exercise tends to produce a short period of acute hypoxia, and acute hypoxia even of short duration produces increased pulmonary artery pressure, decreased cardiac output and increased pulmonary vascular resistance.[15] Studies on the pulmonary circulation during exercise revealed definite abnormalities in chronic pulmonary disease, including a rise in

pulmonary artery pressure and an increase in pulmonary vascular resistance as compared to unchanged or lowered pulmonary artery pressure and pulmonary vascular resistance during exercise in normal subjects.[16,17] A decrease in arterial oxygen saturation with exercise is highly significant in evaluating disability because of the limitation of the magnitude of the increase in pulmonary blood flow during exercise and work imposed by fibrosis of anthracosilicosis. In some individuals arterial oxygen saturation may be essentially normal at rest, but with slight exercise a 10 to 15 percent or even greater decrease results.

The arterial oxygen partial pressure (pO_2) was slightly decreased in group 1 (patients with no pulmonary emphysema) and subnormal in all the other groups with a slightly greater decrease in patients with advanced and far advanced degrees of emphysema, table 3. The arterial partial pressure of carbon dioxide (pCO_2) was increased in the two groups with an advanced and far advanced degree of emphysema, indicating the inability of patients with extensive emphysema (due to increased residual air and usually decreased vital capacity and MBC, the latter limiting hyperventilation) to blow off carbon dioxide adequately. The arterial blood pHs revealed only slight changes in the five groups, table 3. From nervousness and apprehension many of the patients exhibited a considerable degree of hyperventilation even at rest as shown by the pH value, although the use of a nose clip and mouthpiece for breathing will usually increase the arterial blood pH .02 to .03 pH units. The average alveolar pO_2 was decreased only in the groups with advanced and far advanced degrees of emphysema. An increase in the aeration gradient was noted in the two groups with advanced and far advanced degrees of emphysema just as

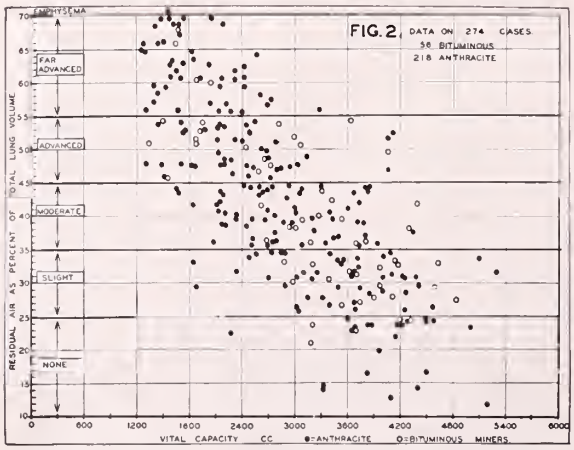

Fig. 2. Correlation of vital capacity and the degree of pulmonary emphysema. Note the similarity of the bituminous and anthracite data.

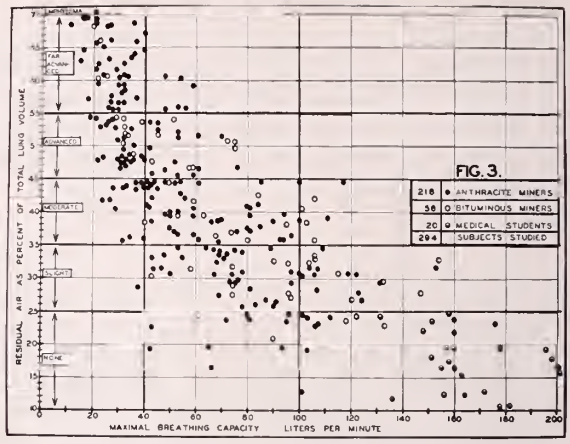

Fig. 3. Correlation of maximal breathing capacity and the degree of pulmonary emphysema. The data on the bituminous and anthracite miners are similar. Note the data on 20 medical students (20 to 30 years of age) used as controls, with an average maximal breathing capacity of 160 liters per minute and a residual air of only 19 per cent of total lung volume.

in the anthracite group.[2] Although the number of bituminous miners studied was much smaller than in the anthracite group, the average aeration gradient was higher in the bituminous group than in the anthracite group.[2] The average transfer gradient was increased slightly in all groups with no correlation with the degree of emphysema, however, the magnitude of the transfer gradient change was significantly less than that noted in the anthracite group.[2] The slightly higher aeration gradient and slightly lower transfer gradient in the bituminous miners would indicate that the distribution factor was not involved to as large an extent as in the anthracite group, although in many cases the transfer gradient was markedly elevated (as high as 40 mm. Hg.). Studies with intermittent positive pressure breathing on air and with high and low levels of oxygenation on bituminous miners with an elevated transfer gradient indicated that the increased gradient is related to the unequal alveolar aeration and perfusion and is not a diffusion difficulty with increased resistance in the pulmonary membrane.[12,13]

The measurements of oxygen uptake and carbon dioxide output permit an evaluation of ventilation efficiency, and these data indicate in general the relationship between perfusion and ventilation in the lung. The data presented in table 3 showed a lack of correlation between the degree of emphysema, the resting ventilation, the percentage of oxygen removed both during rest and exercise and the percentage of carbon dioxide added both during rest and exercise. In the group of patients with an advanced to far advanced degree of emphysema the minute ventilation was significantly reduced with exercise, and the oxygen uptake decreased correspondingly. In most

instances the percent of oxygen removed from and the percent of carbon dioxide added to the air breathed were below the normal values, both at rest and during exercise, table 3. There was no demonstrable evidence that the carbon dioxide values were of greater significance than the oxygen values either at rest or during exercise, as the changes in carbon dioxide addition to the air breathed varied essentially as the oxygen removal values. Studies on 50 cases of anthracosilicosis included both bituminous and anthracite coal miners using the air rebreathing test of Ornstein et al.[18] (described as a method to estimate the capability of the lungs to diffuse oxygen and carbon dioxide) revealed no correlation between this test and the degree of pulmonary emphysema, MBC, vital capacity, arterial oxygen saturation, arterial pO_2, or breathing reserve.[19] In anthracosilicosis the Ornstein rebreathing test was unreliable in evaluating pulmonary function impairment.[19] Wright[20] has also questioned the value of Ornstein's test in evaluating the degree of impairment in pulmonary disease. The many variable factors which may affect the transport of oxygen from the outside air to the arterial blood limit the reliability of any single physiological test in integrating correctly the many abnormal situations which may be revealed when a large number of subjects with chronic pulmonary disease are studied.

The effective percent of resting tidal air (the per cent of the inspired tidal air which reaches the alveoli where gas exchange occurs) decreased progressively from 62 to 52 as the degree of emphysema increased, table 3, however, there were wide individual variations within the groups so that as a single measurement the significance was limited.

Measurements of the percent of oxygen removed from and the percent of carbon dioxide added to the air breathed (even when expressed as respiratory equivalents) were of limited value in evaluating pulmonary function in anthracosilicosis, because the ventilation efficiency was reduced in most of the cases, and the reduction was just as marked in patients with no pulmonary emphysema as in those with emphysema of a far advanced degree. This was similar to the findings on anthracite miners.[2]

The relationship between the duration of dyspnea after one minute of step-up exercise and the degree of emphysema is given in table 3. Wide individual variations were noted, and dyspnea as a single measurement was of limited value in most instances. When the measurements on ventilation, residual air and the respiratory gas exchange revealed a slight to moderate involvement, a prolongation of dyspnea for three to five minutes indicates that the pulmonary circulation may be the primary factor in producing disability (increased pulmonary artery pressure and pulmonary vascular resistance). Further studies on this aspect of the disability in anthracosilicosis are in progress. Pulse and respiratory rate and minute ventilation with the step-up exercise test were of limited value in disability

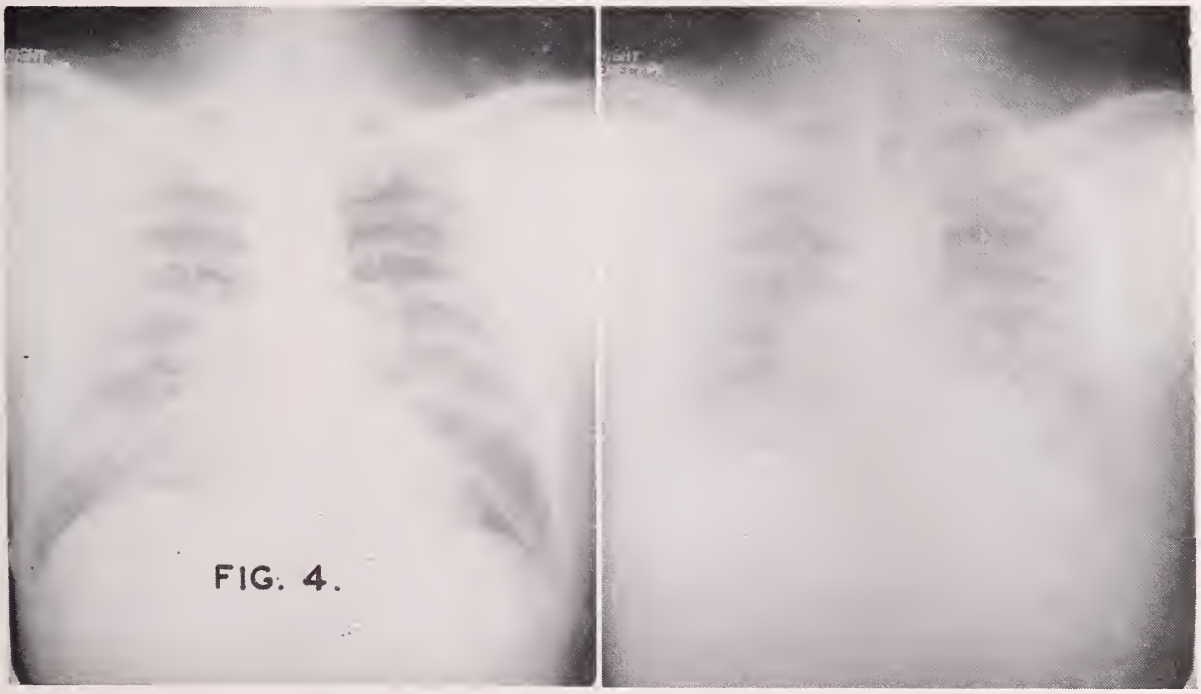

Fig. 4. Case 1, C. D. Inspiratory and Expiratory Roentgenograms.

evaluation. Measurement of the length of dyspnea by the patient's subjective reaction has the restriction of interpretation present in all subjective tests.

The chest roentgenograms were classified in the manner previously described and used for anthracite miners[1,3] which is essentially according to the description of Pancoast and Pendergrass.[21] In this classification the normal or borderline group has no fine mottling of the parenchyma, although increased peri-bronchial markings are present in the borderline group. The first stage was characterized by an increase in the size and density of the hilar lymph nodes, perivascular thickening outwards towards the pleura and a slight fine mottling in the parenchyma. The second stage included the typical nodular round and oblong shadows of soft even density from 2 to 6 mm. in diameter, and the third stage was noted by the presence of shadows larger than 6 mm. in diameter and coalescence into aggregates. The roentgenologic classification of the stage of silicosis in the 56 bituminous cases appears in table 5 correlated with the degree of pulmonary emphysema. There was no apparent relationship between the stage of silicosis as estimated from the roentgenogram and the degree of pulmonary emphysema. The distribution of the cases by the stage of silicosis and the lack of correlation with the degree of pulmonary emphysema was similar to the anthracite findings.[1,3]

Table 5

DEGREE OF PULMONARY EMPHYSEMA VERSUS X-RAY STAGE OF SILICOSIS

Group	*Residual Air % of Total Lung Volume*	*No. of Cases*	*Normal or Borderline*	*1st Stage*	*2nd Stage*	*3rd Stage*
1	25 or less	5	0	0	2	3
2	25 - 35	17	0	2	4	11
3	35 - 45	14	3	2	1	8
4	45 - 55	16	2	5	3	6
5	55 and above	4	1	0	1	2
Total Number		56	6	9	11	30
Percent of Total Number			10.7%	16.1%	19.6%	53.6%

CASE STUDIES

The studies including complaints, chest roentgenograms, pulmonary function measurements and the physiological evaluation are presented on eight representative cases in which the degree of impairment varies from very slight to far advanced (cases 1-8, figures 4-11). The degree of impairment was evaluated on a basis of the ability of the lungs to supply oxygen to the blood both while the subject was at rest and during exercise. These eight cases were selected to illustrate the variable features of chronic pulmonary disease which may be encountered in anthracosilicosis when large numbers of patients are studied, and to help prevent erroneous diagnosis of disability which may occur unless physiological

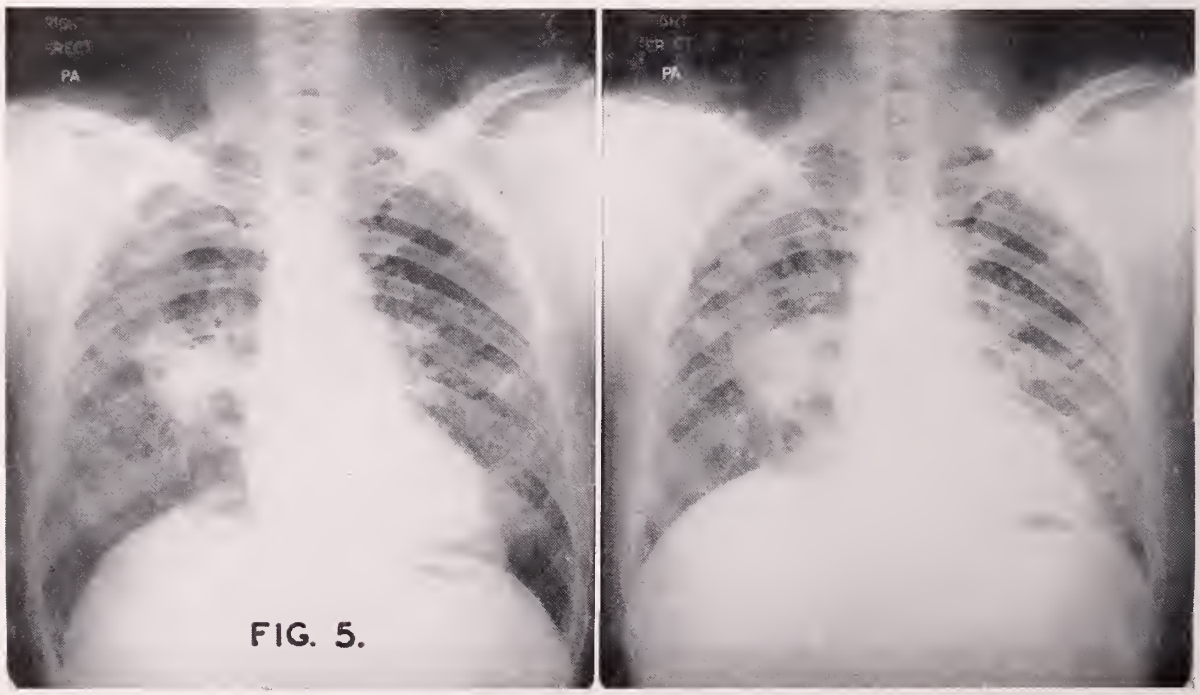

Fig 5. Case 2, J. R. Inspiratory and Expiratory Roentgenograms.

measurements are obtained. The essential data are quantitative measurements on: (1) ventilation (vital capacity and MBC), (2) the degree of emphysema (residual air and the residual air percent of total lung volume), (3) lung ventilation efficiency (percent of oxygen removed and percent of carbon dioxide added to the air breathed) and (4) arterial blood gases (especially arterial oxygen saturation during rest and exercise).

Case 1, C. D. (See Fig. 4)—Age 36—Bituminous Miner 16 years.

Onset of symptoms when rejected by Army because of findings on routine chest roentgenogram. Stopped mining 2 years ago on advice of his doctor. Slight cough and expectoration, weakness and occasional pain in the shoulders. Roentgenologic diagnosis second stage pneumoconiosis.

Pulmonary Function Studies	*Observed*	*Predicted**
1. Maximal Breathing Capacity, L/min.	118	(136)
2. Vital Capacity, cc.	3200	(4490)
3. Residual Air, cc.	830	(1450)
4. Residual Air % of Total Lung Volume	20.6	(24.4)
5. Ventilation, L/min./Sq. M./B.S.A.		
Rest	3.32	(3.0-4.0)
Exercise	12.30	(8.0-11.0)
6. Ventilation Efficiency, O_2 Uptake %		
Rest, amount of O_2 removed from air breathed	4.00	(4.5%)
Exercise, amount of O_2 removed from air breathed	4.58	(5.5%)
7. Arterial Blood Oxygen Saturation %		
Rest	94.8	(96+%)
Exercise	94.6	(96+%)
8. Arterial pCO_2, Rest, mm. Hg.	40	(40)
9. Arterial pO_2, Rest, mm. Hg.	88	(95)
10. Alveolar pO_2, Rest, mm. Hg.	100	(100)
11. Mean Gradient, *Aeration*, pO_2, inspired air to alveolus Rest, mm. Hg.	51	(50)
12. Mean Gradient, *Transfer*, pO_2 alveolus to arterial blood, Rest, mm. Hg.	12	(5)
13. Duration of Dyspnea after exercise, Sec.	102	(60)

14. Evaluation: Very slight degree of pulmonary function impairment due to small decrease in ventilation (maximal breathing capacity and vital capacity). No pulmonary emphysema present. This subject is still able to perform work requiring increased oxygen consumption. Note the lack of correlation between roentgenologic findings and the pulmonary function measurements.

***Predicted values for lung volumes based on the studies of Cournand and Richards and their co-workers.[4-5]**

Case 2, J. R. (See Fig. 5)—Age 57—Bituminous Miner 40 years.

Onset of symptoms two years ago with dyspnea, with progressive increase in severity. Stopped work one year ago because of dyspnea. Moderate cough and expectoration, occasional anterior chest pain and night sweats. One episode of hemoptysis one year ago. Roentgenologic diagnosis third stage pneumoconiosis.

Pulmonary Function Studies	*Observed*	*Predicted*
1. Maximal Breathing Capacity, L/min.	90	(110)
2. Vital Capacity, cc.	3200	(4280)
3. Residual Air, cc.	842	(1835)
4. Residual Air % of Total Lung Volume	20.8	(30.0)
5. Ventilation, L/min./Sq. M./B.S.A.		
Rest	3.63	(3.0-4.0)
Exercise	16.05	(8.0-11.0)
6. Ventilation Efficiency, O_2 Uptake %		
Rest, amount of O_2 removed from air breathed	3.74	(4.5%)
Exercise, amount of O_2 removed from air breathed	3.62	(5.5%)
7. Arterial Blood Oxygen Saturation %		
Rest	96.8	(96+%)
Exercise	94.9	(96+%)
8. Arterial pCO_2, Rest, mm. Hg.	42	(40)
9. Arterial pO_2, Rest, mm. Hg.	84	(95)
10. Alveolar pO_2, Rest, mm. Hg.	97	(100)
11. Mean Gradient, *Aeration*, pO_2, inspired air to alveolus Rest, mm. Hg.	52	(50)
12. Mean Gradient, *Transfer*, pO_2 alveolus to arterial blood, Rest, mm. Hg.	13	(5)
13. Duration of Dyspnea after exercise, Sec.	158	(60)

14. Evaluation: Slight degree of pulmonary function impairment due to small decrease in vital capacity and maximal breathing capacity, decreased ventilation efficiency and slight increase in arterial pCO_2 and in the duration of dyspnea after exercise. No pulmonary emphysema present. The discrepancy was marked in this case between the roentgenological findings and the measurements of pulmonary function.

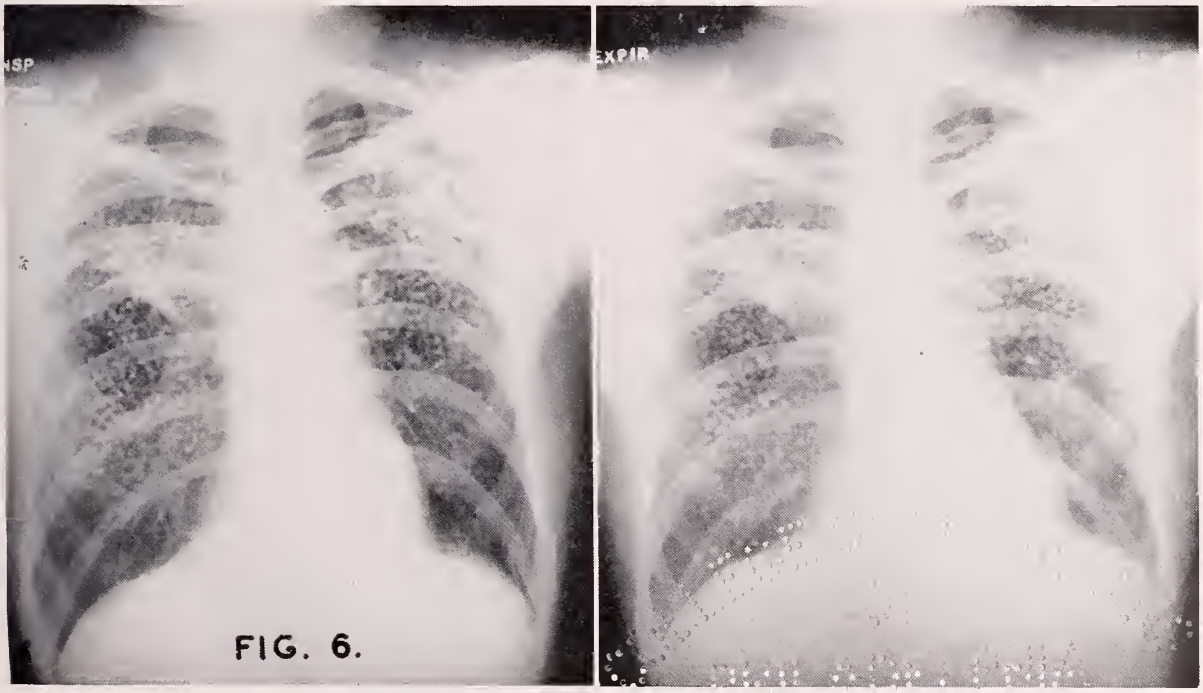

Fig. 6. Case 3, J. Ra. Inspiratory and Expiratory Roentgenograms.

Case 3, J. R. (See Fig. 6)—Age 47—Bituminous Miner 29 years.

Onset of symptoms three years ago with weakness which became marked, followed later by dyspnea present on effort. Slight cough and expectoration, occasional night sweats, fifteen pound weight loss and a sensation of "heaviness" of the chest. Roentgenologic diagnosis third stage pneumoconiosis.

Pulmonary Function Studies	*Observed*	*Predicted*
1. Maximal Breathing Capacity, L/min.	74	(115)
2. Vital Capacity, cc.	3970	(4330)
3. Residual Air, cc.	1677	(1400)
4. Residual Air % of Total Lung Volume	29.7	(24.4)
5. Ventilation, L/min./Sq. M./B.S.A.		
Rest	5.70	(3.0-4.0)
Exercise	10.00	(8.0-11.0)
6. Ventilation Efficiency, O_2 Uptake %		
Rest, amount of O_2 removed from air breathed	3.04	(4.5%)
Exercise, amount of O_2 removed from air breathed	5.37	(5.5%)
7. Arterial Blood Oxygen Saturation %		
Rest	95.1	(96+%)
Exercise	96.0	(96+%)
8. Arterial pCO_2, Rest, mm. Hg.	36	(40)
9. Arterial pO_2, Rest, mm. Hg.	99	(95)
10. Alveolar pO_2, Rest, mm. Hg.	106	(100)
11. Mean Gradient, *Aeration*, pO_2, inspired air to alveolus Rest, mm. Hg.	39	(50)
12. Mean Gradient, *Transfer*, pO_2 alveolus to arterial blood, Rest, mm. Hg.	7	(5)
13. Duration of Dyspnea after exercise, Sec.	220	(60)

14. Evaluation: Slight to moderate degree of pulmonary function impairment present on basis of above measurements, but the prolonged duration of dyspnea indicates that the cardiac output was not increased properly during exercise, and that pulmonary vascular resistance was increased. The prolongation of dyspnea is entirely out of line with the slight decrease in ventilation and the slight degree of emphysema present. The above findings strongly suggest that pulmonary vascular resistance was markedly increased during exercise and that the pulmonary blood flow was not adequately increased to carry sufficient amount of oxygen to the tissues. This latter factor may be the primary cause of disability in chronic pulmonary disease, oxygen gets from the air to the blood satisfactorily but the blood flow is too small to carry a sufficient quantity of oxygen.

Case 4, L. P. (See Fig. 7)—Age 59—Bituminous Miner 46 years.

Onset of symptoms in 1943 with dyspnea and progressive increase in severity. Stopped work in 1946 because of dyspnea. Slight cough and expectoration and moderate weakness. No loss of weight, hemoptysis or chest pain. History of frequent disabling colds. Roentgenologic diagnosis third stage pneumoconiosis.

Pulmonary Function Studies	*Observed*	*Predicted*
1. Maximal Breathing Capacity, L/min.	74	(109)
2. Vital Capacity, cc.	4840	(4540)
3. Residual Air, cc.	1830	(1980)
4. Residual Air % of Total Lung Volume	27.4	(30.0)
5. Ventilation, L/min./Sq. M./B.S.A.		
Rest	4.05	(3.0-4.0)
Exercise	18.78	(8.0-11.0)
6. Ventilation Efficiency, O_2 Uptake %		
Rest, amount of O_2 removed from air breathed	3.33	(4.5%)
Exercise, amount of O_2 removed from air breathed	3.00	(5.5%)
7. Arterial Blood Oxygen Saturation %		
Rest	89.5	(96+%)
Exercise	92.6	(96+%)
8. Arterial pCO_2, Rest, mm. Hg.	40	(40)
9. Arterial pO_2, Rest, mm. Hg.	69	(95)
10. Alveolar pO_2, Rest, mm. Hg.	109	(100)
11. Mean Gradient, *Aeration*, pO_2, inspired air to alveolus Rest, mm. Hg.	38	(50)
12. Mean Gradient *Transfer*, pO_2 alveolus to arterial blood, Rest, mm. Hg.	40	(5)
13. Duration of Dyspnea after exercise, Sec.	122	(60)

14. Evaluation: Moderate degree of pulmonary function impairment due to the small decrease in maximal breathing capacity, the slight increase in residual air with a very slight degree of pulmonary emphysema, arterial oxygen desaturation and the advanced degree of unequal alveolar aeration and perfusion as shown by the increased transfer gradient. The distribution factor produced by the fibrosis is marked in this case and very largely responsible for the impairment. This type of case should respond very well to intermittent positive pressure breathing (IPPB) treatment.[14]

Case 5, E. W. (See Fig. 8)—Age 45—Bituminous Miner 30 years.

Onset of symptoms three years ago with dyspnea that was progressive in severity so that he stopped work one year ago. Moderate weakness and right lower chest pain. There has been a thirty pound weight loss the past four years. A history of disabling colds particularly with changes in weather. Roentgenologic diagnosis early third stage pneumoconiosis.

Pulmonary Function Studies	*Observed*	*Predicted*
1. Maximal Breathing Capacity, L/min.	53	(114)
2. Vital Capacity, cc.	3090	(4540)
3. Residual Air, cc.	2060	(1470)
4. Residual Air % of Total Lung Volume	40.0	(24.4)
5. Ventilation, L/min./Sq. M./B.S.A.		
Rest	4.81	(3.0-4.0)
Exercise	13.35	(8.0-11.0)
6. Ventilation Efficiency, O_2 Uptake %		
Rest, amount of O_2 removed from air breathed	2.85	(4.5%)
Exercise, amount of O_2 removed from air breathed	3.85	(5.5%)
7. Arterial Blood Oxygen Saturation %		
Rest	95.5	(96+%)
Exercise	97.3	(96+%)
8. Arterial pCO_2, Rest, mm. Hg.	43	(40)
9. Arterial pO_2, Rest, mm. Hg.	80	(95)
10. Alveolar pO_2, Rest, mm. Hg.	101	(100)
11. Mean Gradient, *Aeration*, pO_2, inspired air to alveolus Rest, mm. Hg.	50	(50)
12. Mean Gradient, *Transfer*, pO_2 alveolus to arterial blood, Rest, mm. Hg.	21	(5)
13. Duration of Dyspnea after exercise, Sec.	120	(60)

14. Evaluation: Moderate degree of pulmonary function impairment due to extensive reduction in ventilation (vital capacity and maximal breathing capacity), increased residual air producing a moderate degree of pulmonary emphysema, decreased ventilation efficiency both during rest and exercise and increased transfer gradient. By hyperventilation this patient is still able to saturate the arterial blood well for the short intervals, and with the mild exercise test used the arterial oxygen saturation did not decrease, a very significant measurement. Although the hyperventilation compensates for the emphysema present giving a normal aeration gradient, the increased transfer gradient present shows that the distribuution impairment is not compensated with hyperventilation.

Case 6, T. C. (See Fig. 9)—Age 54—Bituminous Miner 30 years.

Onset of symptoms in 1944 with dyspnea. He stopped work on account of the dyspnea in 1947. This patient had worked the entire 30 years as an electric motor operator in the mines. Marked cough and expectoration, slight weakness and lower chest pains. Roentgenologic diagnosis third stage pneumoconiosis. Note the lack of the nodular type, even though the primary exposure for thirty years was sand dust.

Pulmonary Function Studies	*Observed*	*Predicted*
1. Maximal Breathing Capacity, L/min.	100	(103)
2. Vital Capacity, cc.	2940	(4075)
3. Residual Air, cc.	1831	(1745)
4. Residual Air % of Total Lung Volume	38.4	(30.0)
5. Ventilation, L/min./Sq. M./B.S.A.		
Rest	4.95	(3.0-4.0)
Exercise	10.40	(8.0-11.0)
6. Ventilation Efficiency, O_2 Uptake %		
Rest, amount of O_2 removed from air breathed	3.28	(4.5%)
Exercise, amount of O_2 removed from air breathed	2.73	(5.5%)
7. Arterial Blood Oxygen Saturation %		
Rest	94.1	(96+%)
Exercise	87.7	(96+%)
8. Arterial pCO_2, Rest, mm. Hg.	42	(40)
9. Arterial pO_2, Rest, mm. Hg.	73	(95)
10. Alveolar pO_2, Rest, mm. Hg.	94	(100)
11. Mean Gradient, *Aeration*, pO_2, inspired air to alveolus Rest, mm. Hg.	53	(50)
12. Mean Gradient, *Transfer*, pO_2 alveolus to arterial blood, Rest, mm. Hg.	21	(5)
13. Duration of Dyspnea after exercise, Sec.	190	(60)

14. Evaluation: Moderate to advanced degree of pulmonary function impairment due to decreased vital capacity, increased residual air producing a moderate degree of pulmonary emphysema, arterial oxygen unsaturation with an extensive drop during mild exercise, decreased ventilation efficiency and prolonged dyspnea after exercise. This patient was able to hyperventilate during the study period to compensate for the emphysema, but the oxygen gradient of pressure between the alveolus and arterial blood was increased to 21 mm. Hg. (normal 5 mm. Hg.) due to the distribution difficulty of unequal alveolar aeration and perfusion.

Case 7, P. S. (See Fig. 10)—Age 62—Bituminous Miner 35 years.

Onset of symptoms two years ago with dyspnea at which time he consulted a physician for chest pain following a hernia operation, and he was advised to stop work. Moderate cough and expectoration, moderate weakness, left lower chest pain and fifteen pound weight loss past two years. Roentgenological diagnosis negative for pneumoconiosis, but considerable uncoiling of the aorta was noted.

Pulmonary Function Studies	*Observed*	*Predicted*
1. Maximal Breathing Capacity, L/min.	48	(94)
2. Vital Capacity, cc.	3300	(4110)
3. Residual Air, cc.	2690	(1760)
4. Residual Air % of Total Lung Volume	44.9	(30.0)
5. Ventilation, L/min./Sq. M./B.S.A.		
Rest	4.81	(3.0-4.0)
Exercise	11.45	(8.0-11.0)
6. Ventilation Efficiency, O_2 Uptake %		
Rest, amount of O_2 removed from air breathed	2.81	(4.5%)
Exercise, amount of O_2 removed from air breathed	4.49	(5.5%)
7. Arterial Blood Oxygen Saturation %		
Rest	92.5	(96+%)
Exercise	93.6	(96+%)
8. Arterial pCO_2, Rest, mm. Hg.	54	(40)
9. Arterial pO_2, Rest, mm. Hg.	72	(95)
10. Alveolar pO_2, Rest, mm. Hg.	88	(100)
11. Mean Gradient, *Aeration*, pO_2, inspired air to alveolus Rest, mm. Hg.	59	(50)
12. Mean Gradient, *Transfer*, pO_2 alveolus to arterial blood, Rest, mm. Hg.	16	(5)
13. Duration of Dyspnea after exercise, Sec.	145	(60)

14. Evaluation: Moderate to advanced degree of pulmonary function impairment due to the marked decrease in maximal breathing capacity, marked increase in residual air producing a moderate to advanced degree of pulmonary emphysema, decreased ventilation efficiency, increased arterial pCO_2 and decreased arterial pO_2. Even with the hyperventilation present the aeration gradient is increased demonstrating the effect of the increased residual air and emphysema on the mixing and dilution factor. An upper respiratory infection would impair the compensatory hyperventilation and produce marked disability in this case due to the large residual air present, which is always a potential hazard when the volume is markedly increased.

Case 8, S. B. (See Fig. 11)—Age 60—Bituminous Miner 33 years.

Onset of symptoms three years ago with dyspnea, which progressed so that he stopped work one year later. Dyspnea has increased in severity, so that at the present time the degree is very severe. Slight cough, moderate weakness, substernal pain and twenty-two pounds weight loss the past year. Roengenologic diagnosis first stage pneumoconiosis.

Pulmonary Function Studies	*Observed*	*Predicted*
1. Maximal Breathing Capacity, L/min.	27	(85)
2. Vital Capacity, cc.	1940	(4000)
3. Residual Air, cc.	2150	(1715)
4. Residual Air % of Total Lung Volume	52.6	(30.0)
5. Ventilation, L/min./Sq. M./B.S.A.		
Rest	5.15	(3.0-4.0)
Exercise	12.30	(8.0-11.0)
6. Ventilation Efficiency, O_2 Uptake %		
Rest, amount of O_2 removed from air breathed	3.11	(4.5%)
Exercise, amount of O_2 removed from air breathed	3.25	(5.5%)
7. Arterial Blood Oxygen Saturation %		
Rest	92.4	(96+%)
Exercise	82.5	(96+%)
8. Arterial pCO_2, Rest, mm. Hg.	47	(40)
9. Arterial pO_2, Rest, mm. Hg.	72	(95)
10. Alveolar pO_2, Rest, mm. Hg.	84	(100)
11. Mean Gradient, *Aeration*, pO_2, inspired air to alveolus Rest, mm. Hg.	69	(50)
12. Mean Gradient, *Transfer*, pO_2 alveolus to arterial blood, Rest, mm. Hg.	12	(5)
13. Duration of Dyspnea after exercise, Sec.	165	(60)

14. Evaluation: Far advanced degree of pulmonary function impairment due to: very marked decrease in vital capacity, maximal breathing capacity, increased residual air producing an advanced degree of pulmonary emphysema, decreased ventilation efficiency, arterial oxygen unsaturation

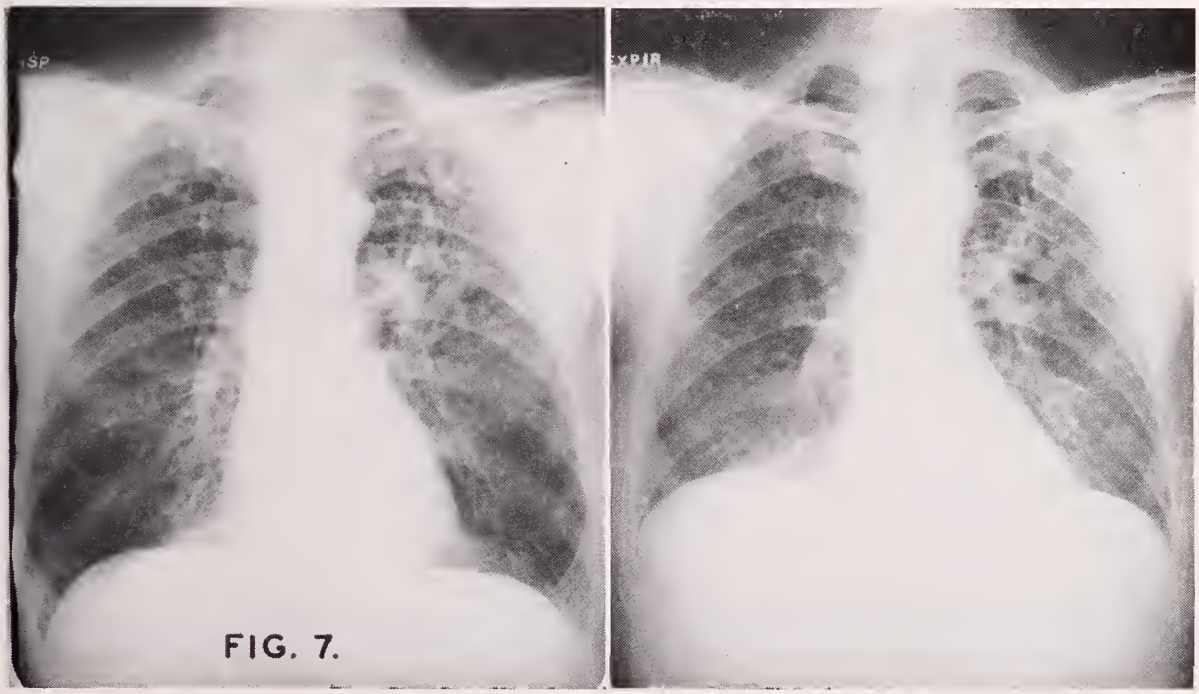

Fig. 7. Case 4, L. P. Inspiratory and Expiratory Roentgenograms.

with a marked drop with exercise, increased arterial pCO_2, decreased arterial pO_2 and alveolar pO_2. The marked degree of emphysema reflects in the increased aeration gradient due to the mixing and dilution imposed by the increased residual air in the presence of impaired ventilation. This patient is completely incapacitated for performing work requiring increased oxygen consumption.

The studies on respiratory gas exchange as presented in the data for cases 1 to 8 revealed a lack of correlation between the extent of the function impairment and the roentgenological findings, similar to observations and measurements previously reported on anthracite miners.[2,3]

The inspiratory and expiratory roentgenograms of these cases were helpful in evaluating the degree of emphysema, but provide little information on the respiratory gas exchange involvement.

The representative case studies demonstrate wide individual variations and illustrate that the major factors producing pulmonary function impairment may act singly or in combination and with wide individual variations.

DISCUSSION

Anthracosilicosis[22] (miners asthma) or coal miners pneumoconiosis is a disabling occupational disease. The correct evaluation of the extent of this disability presents clinical difficulties in many cases. Although a good history, physical examination and radiological study are important, the information provided by these is often inadequate for determination of the extent of the respiratory disability. Disability is a loose term that requires more exact definition than merely the inability to work, for there are many types of work and an individual incapacitated for one job, might yet be capable of performing another. In this study disability refers solely to the functioning of the lungs, and their ability to transport oxygen from the air to the blood and to remove carbon dioxide adequately while breathing air both during rest and exercise.

Physiological tests necessary to evaluate the extent of pulmonary function impairment are of five main types as shown in figure 12. The distribution impairment was determined from measurements on arterial blood and expired air. Emphysema and the distribution factor are the two primary causes of a lowered arterial oxygen saturation in anthracosilicosis.

(1) *Ventilation Mreasurements:* Vital capacity and maximal breathing capacity are the two most important. Vital capacity in general decreases as the degree of emphysema increases, but the wide individual variations limit the usefulness of this measurement alone unless the values are extreme, very low (1500 cc. or less) or very high, above 4000 cc. A vital capacity of 2000 to 3000 cc. may exist without emphysema or with a far advanced degree of emphysema. Maximal breathing capacity (MBC) presented a relation to the degree of emphysema similar to that between vital capacity and emphysema, however, if the MBC was less than 40 liters per minute a significant degree of emphysema was present in most cases, and if the MBC was over 100 liters per minute the degree of emphysema was in-

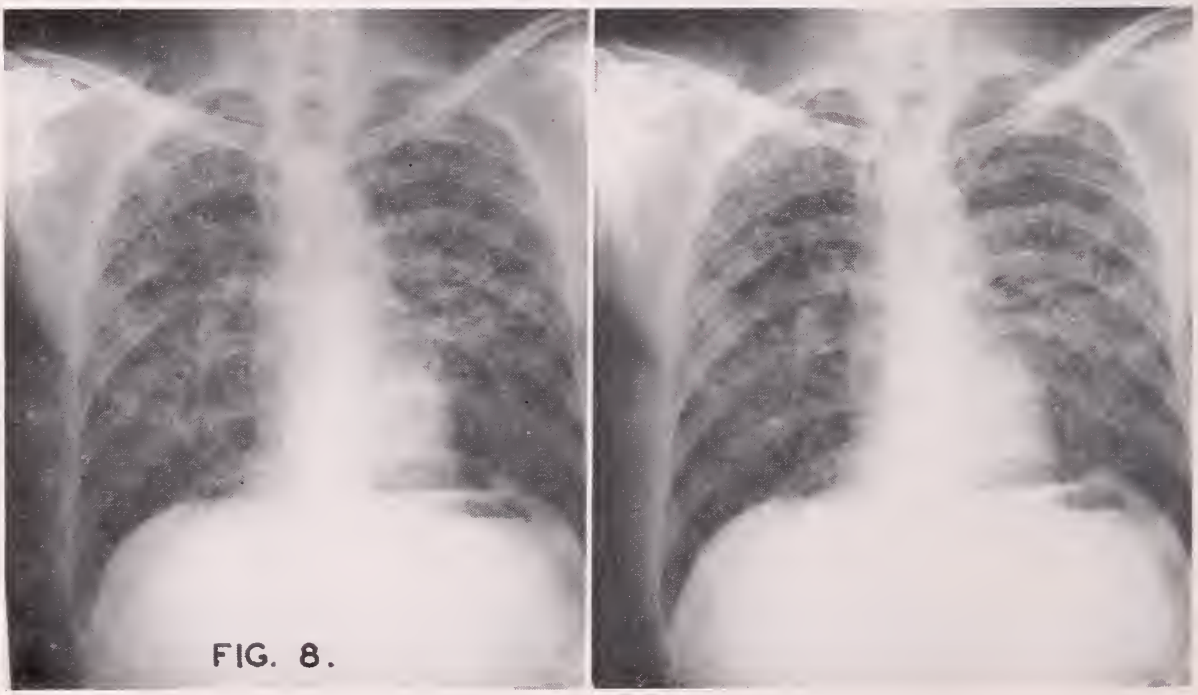

Fig. 8. Case 5, E. W. Inspiratory and Expiratory Roentgenograms.

significant. The significance of the MBC measurement was limited in the range from 40 to 100 liters per minute. In the groups with a significant degree of emphysema, MBC measurements were consistently reduced farther below the predicted values, than were the vital capacities. MBC appears to have considerable practical value in the early detection of fibrosis with loss of lung elasticity. A young individual (20 to 40 years of age) should not be permitted to work in an environment exposed to silica dust if his MBC is less than 100 liters per minute, for if the MBC is less than 100 liters per minute, loss of lung elasticity has occurred probably from fibrosis. It would appear desirable to have the MBC measurement a routine procedure along with the chest roentgenogram. If annual MBC measurements showed progressive decrease, fibrosis and loss of lung elasticity with obstruction would be developing and the individual should be removed from the particular environment if there is a dust hazard regardless of the roentgenological appearance of the chest.

(2) *Emphysema:* The degree of emphysema is a very significant measurement. All degrees of emphysema occur in all age groups, and without apparent correlation with the roentgenologic stage of silicosis. An increased volume of residual air constitutes a potential hazard in the presence of upper respiratory infections and with increased bronchospasm, because both conditions limit the amount of hyperventilation possible without dyspnea.[3] Emphysema of a far advanced degree is disabling per se, and an evaluation of pulmonary function impairment may be made on this basis (residual air and vital capacity). The quantitative classification of emphysema[1] shown in table 2 has proven satisfactory for grouping the cases for study and analysis of the data as is shown by the close correlation with other physiological measurements.[1,2] Some patients with an increased residual air had slight disability, but since the vital capacity was good, compensation was maintained by hyperventilation, and the dyspnea level was not reached even with mild exercise. In over one third of the bituminous miners studied the degree of emphysema was not significant.

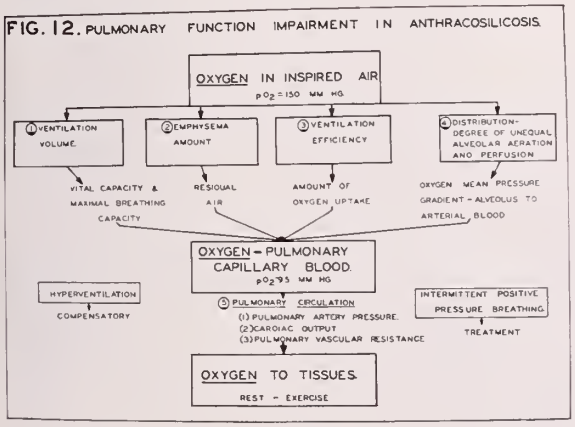

Fig. 12. A schematic diagram of the factors which may interfere in the transport of an adequate oxygen supply to the blood and tissues. Information provided by physiological tests permits an evaluation of all the factors which may contribute singly or in combination to impair oxygen transport. Hyperventilation is a compensatory mechanism, and intermittent positive pressure breathing is a treatment method.[11]

(3) *Lung Ventilatory Efficiency:* The ventilation efficiency of the lung as measured by the oxygen uptake and carbon dioxide output had a limited significance in evaluation. If the oxygen uptake decreased markedly with exercise, this measurement was significant for the individual case, but provided slight information as to the nature of the impairment other than to indicate the existence of a disproportion pertaining both to the intrapulmonary mixing of inspired air and the pulmonary blood flow. The removal of oxygen per given volume of air breathed was below the normal level in the majority of the coal miners studied. In some cases, most often in patients with extensive emphysema, the amount of oxygen removed during exercise per volume of air breathed was less than during rest, and therefore the patient had to breathe a larger volume of air to get the same amount of oxygen into the blood; for example if during exercise only 2.0% of oxygen were removed from the inspired air, then 5 liters of air were required for each 100 cc. of oxygen supplied, and the amount of work possible was limited by the inability to hyperventilate adequately to meet the oxygen requirement. Measurements of the amount of carbon dioxide removed from the blood were more or less parallel with those for oxygen uptake. Oxygen uptake and carbon dioxide output determinations are useful for evaluation of disability when applied with the other tests, but these measurements should not be used alone.

(4) *Arterial Blood Gases:* The arterial oxygen saturation as determined from the oxygen content and capacity at rest and during exercise was a very important measurement. Arterial oxygen partial pressure (pO_2) and carbon dioxide partial pressure (pCO_2) are very helpful in localizing the nature of the oxygen transport difficulty in the lungs, but these data are not essential to evaluation of the disability. A single resting arterial blood saturation measurement had but limited value unless it was extremely low, because wide individual variations occur, accompanied by only slight average changes. Measurements of the arterial oxygen saturation immedi-

ately following the step-up exercise revealed significant differences with respect to the degree of emphysema and the existing disability. The exercise arterial oxygen saturation data were striking in the group of subjects with a significant degree of pulmonary emphysema, in general the more marked the emphysema the greater the decrease in oxygen saturation with exercise. In some cases, however, the arterial oxygen saturation was increased after exercise even in the presence of extensive emphysema, and was decreased in others with no emphysema. There was no apparent means of predicting in advance the effect of exercise on the arterial oxygen saturation. An individual with a resting arterial oxygen saturation less than 90% may be able to do a

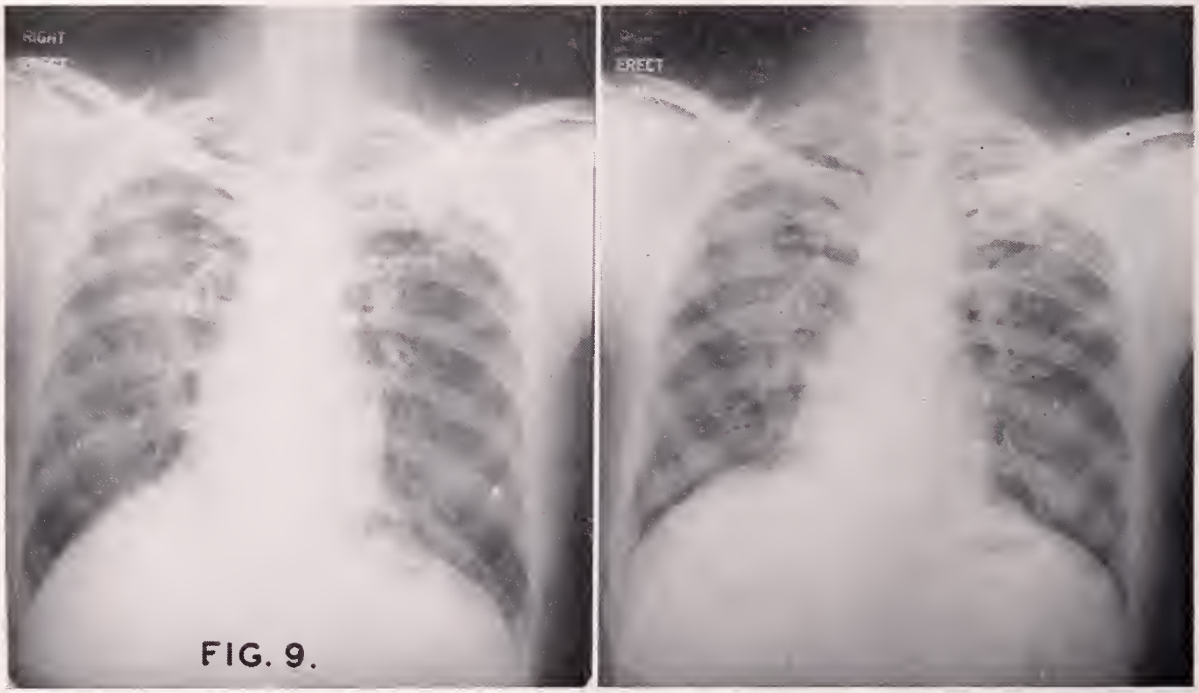

Fig. 9. Case 6, T. C. Inspiratory and Expiratory Roentgenograms.

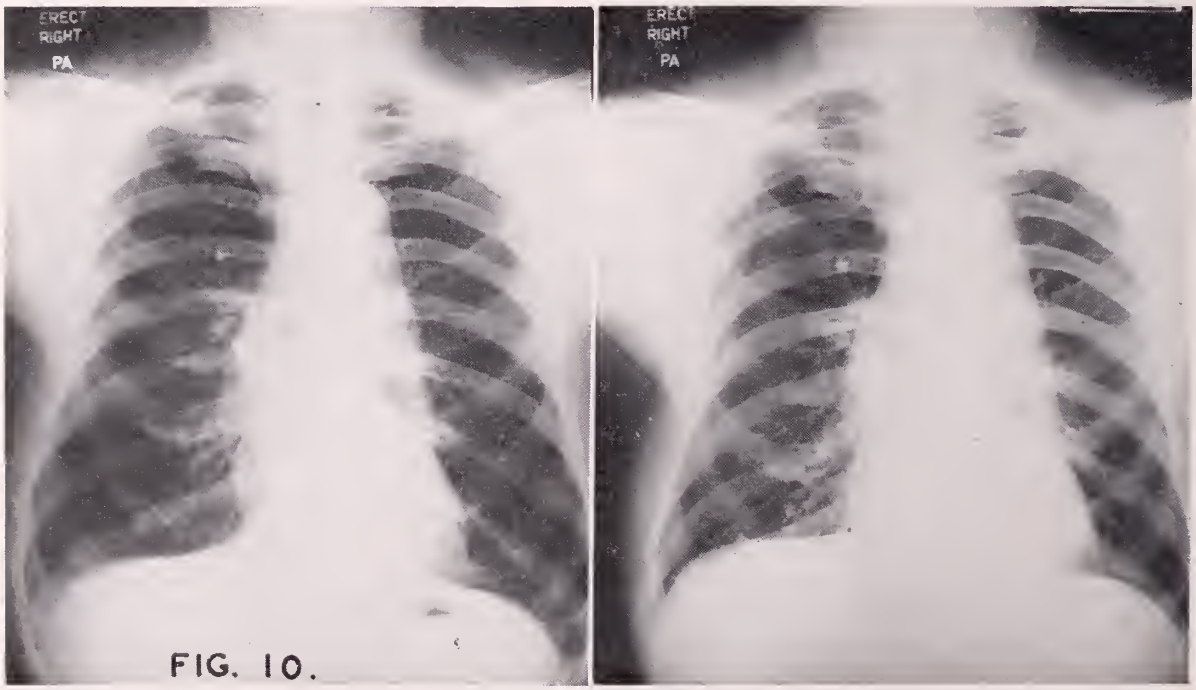

Fig. 10. Case 7, P. S. Inspiratory and Expiratory Roentgenograms.

moderate amount of work if during exercise there is a slight increase, a situation which occurs fairly frequently. If there is a marked drop (5 to 10%) in the oxygen saturation of the arterial blood during exercise, the impairment is obviously severe. Measurements of arterial pO_2 and pCO_2 have provided a means of study of the nature of the oxygen transfer difficulty in anthracosilicosis. A distribution difficulty (unequal alveolar aeration and perfusion) has been found to be the primary factor producing an increased oxygen gradient between the alveolus and arterial blood with a resulting lowering of arterial oxygen saturation. In some alveoli fibrosis obliterates, to a greater or lesser degree, the blood flow through the alveolar capillaries resulting in ventilation without perfusion. In other alveoli fibrosis produces varying degrees of air circulation impairment (loss of lung elasticity and narrowing of the bronchiolar lumina), so that although blood perfusion be present, ventilation is impaired partially or completely. Alveoli which are perfused but non-aerated present circulatory pathways which act as small shunts (venous admixture) and thus lower arterial oxygen saturation. Impaired circulation of air in the alveoli lowers the alveolar pO_2 and the blood leaving these alveoli is unsaturated. The distribution factor is independent of the degree of emphysema, occurring in all groups and ages and without any apparent correlation with the roentgenologic stage of silicosis. Chronic tracheobronchitis combined with bronchospasm further interferes with the uniform aeration of alveoli.

(5) *Pulmonary Circulation:* The four main measurements of pulmonary function described are usually the most significant and permit accurate evaluation of the pulmonary impairment in most cases, but the fifth factor, which may be the major one, in disability in some cases is the pulmonary circulation. At the present time studies are being extended to investigate the pulmonary circulation factor in anthracosilicosis, including measurements of pulmonary artery pressure and cardiac output with calculations of pulmonary vascular resistance.

Other measurements presented in table 3 which are of limited value in evaluating the degree of pulmonary function impairment are: arterial CO_2 content, arterial pH, minute ventilation, oxygen uptake, resting tidal air and percent effective tidal air. The duration of dyspnea after exercise was quite variable and in general poorly correlated with the other finding unless abnormally increased. The presence of prolonged dyspnea, 3 to 5 minutes after the step-up exercise, was significant. Pulse rates and respiration rates at rest and during exercise were of slight value and showed no correlation with the overall physiological evaluation of the impairment.

The studies on pulmonary function in anthracosilicosis of bituminous miners revealed physiological disturbances quite similar to those found

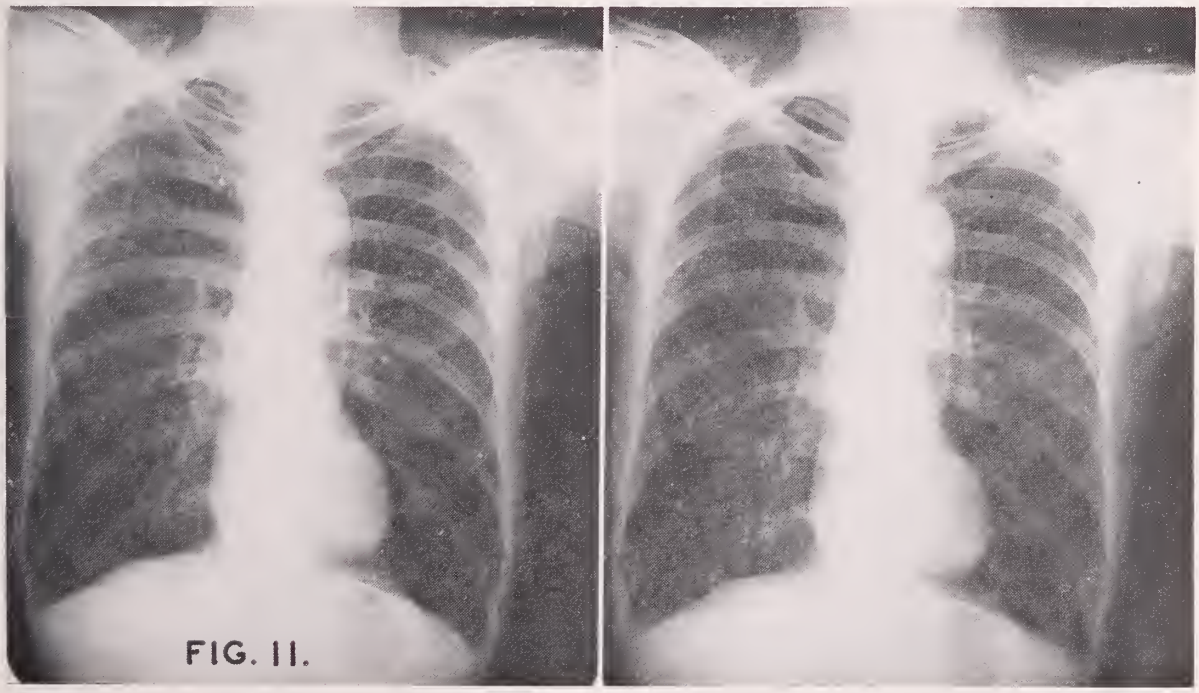

Fig. 11. Case 8, S. B. Inspiratory and Expiratory Roentgenograms.

in anthracosilicosis of anthracite miners. There was no characteristic feature of the chest roentgenogram to differentiate an anthracite from a bituminous miner. Although the number of bituminous miners on whom complete physiological studies have been made is small (56) in comparison to the number of anthracite miners studied, there appears to be a slightly greater amount of emphysema and somewhat less distribution involvement in the anthracosilicotic bituminous miners. Individual cases exhibit marked variations in the degree of involvement of the various factors. The individual case cannot be diagnosed from the function studies, for there was no typical pattern which separates the bituminous from the anthracite miner.

CONCLUSIONS

1. The physiological disturbances of respiration in anthracosilicosis were similar in bituminous and anthracite miners.

2. No single test was adequate in evaluating the pulmonary function impairment in bituminous miners. The chest roentgenogram was poorly correlated with function changes.

3. Measurements of vital capacity, maximal breathing capacity, residual air and the degree of emphysema, efficiency of the lungs for oxygen uptake, arterial blood oxygen saturation and the duration of dyspnea after exercise were the most important tests in evaluating the impairment. In selected cases measurements on the pulmonary circulation are necessary.

4. The resting arterial oxygen saturation alone was poorly correlated with pulmonary function impairment, because the respiratory gas exchange measurements might be essentially normal at rest, although during exercise gross abnormalities became manifest.

5. A significant degree of pulmonary emphysema occurred in about two-thirds of the cases studied. Fibrosis may result in disability without increasing the residual air by decreasing ventilation capacity and producing unequal alveolar aeration and perfusion (distribution factor).

6. The distribution factor (unequal alveolar aeration and perfusion resulting from the fibrosis) is primarily responsible for the increased oxygen gradient between the alveoli and the arterial blood rather than a true diffusion difficulty with an increased resistance in the pulmonary membrane.

7. The limitation of compensatory hyperventilation as a result of reduced vital capacity and maximal breathing capacity produces most of the subjective complaints of dyspnea.

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NEW LIGHT ON CANCER

The American Cancer society has reported that some types of cancer have been checked thru treatment with the newly discovered hormones known as ACTH and cortisone. The cancers, instead of growing, have shrunk.

The announcement was hedged about, as early reports of medical discoveries usually are and always should be, with many cautionary words. The treatment is still in the experimental stages. It does not benefit all types of cancer. The patients cannot be pronounced cured; all that can be said is that the progress of the disease has been arrested.

While, then, it is still far too early to say whether ACTH or cortisone will cure or even permanently arrest any type of cancer, there can be no quarrel with the statement of Dr. J. R. Mote, medical director of Armour & Co., that "this is probably the greatest thing in medicine since Pasteur's discovery of bacteria." That is so because, as he said, a broad new era in medicine has been uncovered. The doctors have been given not only new drugs to be tested, but new insights into human physiology which may prove of immense value in understanding the nature of health and disease.

ACTH and cortisone are the big news of 1949 and, in the perspective and history, may well dwarf in importance everything that the political leaders and military men of all the nations have said and done in a decade of war and revolution. Maybe the medical scientists are going to do more in the next few months and years to relieve misery than the statesmen have done to generate it.

In this connection it should be noted that the new discoveries owe little or nothing to government activity. The idea came from scientists who were not in government service. The drugs are being produced by private industry. It is said that Armour & Co., whose laboratories are the source of ACTH, has spent 3 million dollars on this project and has yet to receive even a penny for a dose of the drug. Armour & Co.'s last annual report showed a loss for the year on all operations of something over 2 million dollars.

The New Dealers say that American business is short sighted, dollar crazy, and in need of government guidance. Likewise, American medicine, so the New Dealers say, will never do its job properly until the government runs it. The story of ACTH and cortisone proves how false is the New Deal's propaganda.—Chicago Daily Tribune.

CHRONIC ILLNESS PRIMARY MEDICAL PROBLEM

Today, as medical science moves forward in the prevention and cure of infectious disease, chronic illness has become the nation's primary medical problem.

One of the principal causes of the increasing prevalence of chronic disease has been the great advances in medical and surgical care which have prevented death and produced an aging population. Two thousand years ago, the average length of life was 25 years; at the turn of the century, it was 49; today, it is 66. In 1900, 1 person in 25 was 65 years of age or older; it is estimated that in 1980, the ration will be 1 in 10. The chances are now two out of three that a young man now starting his working life at the age of 18 will live to his retirement age of 65.

As people become older, their medical needs change, and they demand more medical service. In 1940, the 26.5 per cent of the nation's population over 45 required over half of the nation's medical services. By 1980, it is expected that the number of persons over 45 will constitute nearly half of the population.—Howard A. Rusk, M. D., in Virginia Medical Monthly.

CRACKING JOINTS

Weather factors predispose to cracking of joints. Most common is chilling as produced by low temperatures combined with high humidity. Heavily ironized air, particularly during storms, is a less frequent but potent factor predisposing to cracking of joints.

During the month of July both chilling and cracking of joints were common in San Francisco, uncommon in Portland and Seattle, and rare in New York City.

The noise heard in joint cracking may be the sound produced by the stretching of contracted, inflamed fibrous tissue found in fibrositis.

Fibrositis is becoming recognized as extremely ubiquitous, one authority considering it the most common ailment to which human flesh is heir.

Toxin, probably streptococcal, from foci of infection is the usual agent producing fibrositis. Chilling of the body and ionized air predispose to an increase in bacterial activity and the production of toxin. This blood-borne toxin affects fibrous tissue located throughout the body. The affected fibers shorten. A degree of stiffness results. Flexing or hyperextending the involved joints stretches the fibers with a cracking noise.—Edward E. Brown, M. D., in Northwest Medicine.

SHOCK TREATMENT FOR PSYCHOSES

Shock treatment is beneficial for functional psychoses, but many patients so treated suffer a regression of their mental illnesses shortly after the treatment is completed.—J. F. in Ohio State Med. J.

The President's Page

On January 1, 1950, I shall assume office as president of the West Virginia State Medical Association. I do this with deep humility and with full realization of the responsibilities of the office.

Had he lived, Russ Bailey would have been president. His loss, as a friend and as a doctor, will be felt in West Virginia for years to come. That he would have had a successful term, there can be no doubt. The best I can offer in his stead is the pledge that I shall discharge the duties of the office to the very best of my ability.

On behalf of the Association, I want to express appreciation to Tom Reed for the tireless, efficient way he has carried on for us during the past year. He deserves the wholehearted thanks of each and every member of our group.

It is my duty to appoint members of various Association committees, and the chairman and personnel of these committees have been selected with the greatest of care. I hope that each doctor so appointed will serve during 1950.

I look forward with pleasurable anticipation to my year as president. I shall make every effort to visit all component societies and to become better acquainted with the membership.

A happy New Year to each and every member of the Association.

C. E. Watkins

President.

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Charles E. Watkins, M. D.

NEW PRESIDENT IN OFFICE

When this issue of The Journal reaches the members of the West Virginia State Medical Association, we will have a new president in the person of Dr. Charles E. Watkins, of Oak Hill. He succeeds Dr. Tom Reed, of Charleston, who automatically becomes chairman of the Council. The present chairman, Dr. Tom Bess, of Keyser, will serve as member-at-large during 1950.

We have known Charlie Watkins for many years. We are acquainted with his background, and feel that he is especially well qualified to fill the important office of president. Reading his first "President's Page," we are impressed with his modesty, but more with his solemn pledge to serve to the best of his ability.

These are critical times, not only for the medical profession, but for all allied groups. We must remain united if we are to stay free from federal bureaucratic supervision or control. Charlie Watkins will oppose vigorously all the forces that seek the distruction of a free profession. He will fight relentlessly for the group whose very existence is threatened.

The new president is an eminent and successful general practitioner in the Oak Hill area. He is a born leader and assumes his new duties with the good wishes of all the members of his group. He will point the way and will receive full support in solving the problems which face the profession as the New Year dawns.

Congratulations, President Watkins, and best wishes for a successful term.

THE WELFARE FUND

We have heard whisperings to the effect that the United Mine Workers Welfare Fund has been wrecked by the inroads of the medical profession; that it will lead to state medicine, etc.

While exact figures as to medical costs are not yet available, we have information to the effect that, by and large, the fees charged by individual physicians have been reasonable and satisfactory to the Fund management; so satisfactory indeed that there is no contemplated fee schedule in the offing.

The questionable fees submitted have been very occasional and far between, although a few have been exorbitant. These have been so few, however, as to be practically negligible.

As to the charge that the operation of the Welfare Fund will lead to state medicine, it will in our judgment, have exactly the opposite tendency. As set up, the working of the Fund certainly is at least a corollary of free enterprise, so to speak. The plan has been worked out in the

various states in conjunction with the organized medical profession, and, in those states which have liaison committees of the state medical associations, controversies have been even fewer than elsewhere.

The Plan actually gives the patient reasonably free choice of physician and hospital, certainly along the lines of normal patient flow from his home community, and there is in actual practice no disturbance of the time-honored doctor-patient relationship. The doctor is not hampered as to examination and treatment; he gives the patient what, in his own judgment, is necessary, and submits his bill for service rendered.

There is no compulsory legal element or tax in the procedure. Certainly this is the very antithesis of compulsory governmental health insurance.

As far as our observation of the Fund has gone, the profession is satisfied and the patients are likewise satisfied. Certainly it has ameliorated the lot of the miner medically and has pioneered in the field of labor-medical relationships. Experiences have been gathered and guideposts have been erected which might well be considered by other welfare funds now being set up when they come to furnishing actual medical service to their beneficiaries.

RETIRING PRESIDENT HEADS COUNCIL

Dr. Thomas G. Reed, of Charleston, who will on January 1 retire as president of the West Virginia State Medical Association, but who automatically takes over as chairman of the Council, will be no stranger so far as the work of this group in 1950 is concerned. He served for four years as a member of the Council prior to his election as president, and has been thoroughly acquainted with the problems of the Association for several years.

As president, he was very active in the fight for a four-year school of medicine and dentistry in this state, a fight that most definitely has not been lost. This particular problem, so important to all of our people, will probably constitute one of the principal planks in any legislative program adopted for consideration by the Legislature in 1951.

Doctor Reed has during the past year been most active in handling the affairs of the office of president, and, with Dr. Tom Bess and the other members of the Council continuing in office for another year, he will have an experienced group to act with him in the Council's work during 1950.

Doctor Reed has made a good president, and we predict for him a successful year as chairman of the Council.

A. M. A. MEMBERSHIP

At the recent Washington meeting, the House of Delegates of the American Medical Association authorized dues for membership in the sum of twenty-five dollars per annum. This was shown to be absolutely necessary to carry on the work now incumbent upon the Association, including the continuation of the educational campaign against the threat of compulsory governmental health insurance.

Prior to 1948 the income from publications and fellowship dues was sufficient to meet running expenses, but the extension of activities, especially the educational campaign against the socialization of medicine, necessitates annual dues. The vote was unanimous.

The threat of state medicine is so great that the profession *must* stand together and support the House of Delegates in the matter of dues. All that prevents state medicine in this country is the determined stand of the A. M. A. The British Medical Association lost its fight against socialization because the members did not stand together. United we can win, but *we must present a solid front. Let's stand together and remain a free profession.*

A SAGE COMMENT

One of the most sage comments of the year was that of Dr. Andy Hall of Mt. Vernon, Ill., who, during the past week, was named the "Outstanding General Practioner of the Year" by the American Medical Association.

Said Dr. Hall:

> "There are only two places where Socialism might work. One is in heaven where Socialism is not needed, and the other is in Hell where they already have Socialism."

It was not necessary for the good doctor to point to the failures in trying to make Socialism work in England, or the failures of our own federal administration in trying to pattern after those failures of England in attempting to set up a "welfare state" in the United States.— Parkersburg News.

SURGERY WITH POISONED ARROWS

An interesting discussion of the merits of Curare is contained in a recent release by the American Society of Anesthesiologists, Inc. The

information supplied is timely, interesting and informative, and for these reasons the article is reproduced in its entirety:

Since the days of Sir Walter Raleigh, "flying death", the magic arrow poison of the South American Indians, has been known to white men, yet because of the peculiar role played by Curare, the poison used, its nature remained the carefully guarded secret of a few selected natives. Although the pharmacological action of Curare has been known for about a century, it was essentially a laboratory curiosity.

In 1938 Richard C. Gill, an American, who had lived for years in the upper Amazon jungles of Ecuador, brought back to the United States the first adequate supply of the various plants which were used by the Indians in the production of crude Curare for their poisoned arrows.

Through intensive scientific investigation by prominent pharmacologists and modern research laboratories, useful pure products of Curare were made available, of which the most important one is d-tubocurarine chloride. The Curare products used in medicine today are preparations of high purity, properly standardized and controlled.

After extensive laboratory experimentation and clinical investigation, it was found that the drug, skillfully used, induced relaxation of muscles, a condition greatly to be desired in many types of modern surgery. The drug also has a wide field of usefullness for its relaxation properties in all fields of medicine.

Today, Curare in the hands of the skilled anesthesiologist, permits him to achieve for the surgeon necessary muscle relaxation without the use of anesthetic agents of a kind or in quantities so great as to endanger human life. Surgical manipulations within the abdomen are always aided by a state of adequate muscular relaxation associated with quiet breathing.

Curare in the hands of the trained anesthesiologist has made it possible to obtain any required degree of relaxation at will without dangerously deepening the anesthesia or resorting to the more difficult anesthetic procedures formerly sometimes found necessary. By achieving this state without increased hazard to the patient, the anesthesiologist assists the work of the surgeon and contributes directly to a smoother, more complete and a more rapid recovery of the patient.

Thus, through the constant alertness and scientific endeavors of the explorer, the pharmacologist, the research laboratories and the Anesthesiologist, new surgery has been made possible with greater safety to the patient. This, then, is the story of the transformation of a poison from the kettles and gourds of Indian witch doctors to a standardized drug in the sterile ampules of modern medicine.

VA MEDICAL CARE

The attention of all members of the West Virginia State Medical Association who are participating in the veterans care program is called to a letter from Dr. Leo F. Steindler, Chief of the Medical Division at the VA Regional Office in Huntington, which is printed under "Correspondence" in this issue of The Journal.

Over a thousand member of the Association have been certified for VA work, and a clear understanding of the regulations is necessary to assure the success of the program. It is hoped that all members rendering out-patient care in their home communities will read carefully the points brought out by Doctor Steindler in his letter.

THE DOCTOR'S RESPONSIBILITY

Doctors have tremendous obligations as citizens. They need to take part in helping a sick society to recover and to aid in the creation of a more stable society. Physicians are as capable of knowing human needs and of understanding human relations as any group in our society. It behooves our medical men to be good citizens as well as good doctors. Interest in public affairs today is a major responsibility of the medical profession since there is so much at stake.

In your home communities, each of you is a symbol of free American medicine. As a doctor-citizen you have it especially within your power right now to play a major part in saving our American Way of Life.—Robt. E. Robins, M. D., in New York Medicine.

FACTS AND FIGURES

Samuel Gompers, as President of the American Federation of Labor, said: "Look over all the world, where you will, and see those governments where the features of compulsory benevolence have been established, and you will find the initiative taken from the hearts of the people."

Mr. Oscar Ewing, stated that present voluntary health plans are inadequate in every way. He says they cover only 32,000,000 persons with limited hospital care.

The Health Insurance Council has just issued its report for the year 1948. This Council is made up exclusively of trade organizations in the insurance field. There report is a survey on the extent and scope of voluntary protection against the economic hazards of illness and accident. This report is enlightening and is quite contradictory to Mr. Ewing.

The number of persons in the United States subscribing to some form of voluntary insurance providing hospital care at the end of 1948 was 60,995,000. The breakdown of this total shows the number covered in the various catagories is:

Hospital expense	60,005,000
Surgical expense	34,060,000
Medical expense	12,895,000

The Council's figures further reveal that 25,984,000 of the total covered for hospital expenses had obtained protection on an individual and family basis through insurance companies and fraternal societies; the Blue Cross Plans and similar coverage, sponsored by medical societies, accounted for 31,246,000 of the total; and "other organizations" such as the bituminous coal industry, consumer-sponsored groups and other industrial plans were responsible for 3,765,000.

These figures omit such types of protection as Workmen's Compensation, commercial accident policies of various kinds, and specific policies offered by insurance companies: N. Y. Medicine.

GENERAL NEWS

PRESIDENT CHARLES E. WATKINS NAMES NEW COMMITTEES FOR 1950

Standing and special committees for 1950 have been named by Dr. Charles E. Watkins, of Oak Hill, who assumes his duties as president of the West Virginia State Medical Association on January 1.

Key Committees Merged

Under the provisions of an amendment to the by-laws adopted at the annual meeting at White Sulphur Springs last August, the Fact Finding and Planning Committee and the Legislative Committee were merged under the name of the Fact Finding and Legislative Committee. Dr. D. A. MacGregor, of Wheeling, chairman of the present Fact Finding Committee and Dr. Frank V. Langfitt, of Clarksburg, Legislative Committee chairman, have been named as members of the new committee, and Doctor MacGregor will serve as chairman.

Dr. Frank J. Holroyd, of Princeton, who has done outstanding work during the past year as head of the Public Relations Committee, has been renamed to that position by Doctor Watkins. This committee, which will on January 1 take over the duties of the special committee on Rural Health, has already sponsored several meetings with rural groups, and a statewide rural health conference is planned for early spring.

Committee Chairmen

Dr. Philip W. Oden, of Ronceverte, will serve as chairman of the Cancer Committee, succeeding the late Russell B. Bailey, M. D., of Wheeling, and Dr. J. J. Brandabur, of Huntington, succeeds Dr. J. L. Patterson, of Logan, as chairman of the committee on Industrial Health.

Dr. Bert Bradford, Jr., of Charleston, succeeds Dr. Hu C. Myers, of Philippi, as chairman of the committee on Medical Education, and Dr. R. R. Summers, of Charleston, will serve as chairman of the Necrology Committee, succeeding the late Harry G. Steele, M. D., of Bluefield.

Dr. Sobisca S. Hall, of Clarksburg, and Dr. Hugh A. Bailey, of Charleston, will continue as chairmen, respectively, of the committee on Revision of Constitution and By-Laws and the DPA Advisory Committee.

Dr. N. H. Dyer, of Charleston, succeeds Dr. C. A. Hoffman, of Huntington, as chairman of the Syphilis Committee, and Dr. W. P. Bittinger, of Summerlee, will serve as chairman of the committee on Tuberculosis, succeeding Dr. George F. Evans, of Clarksburg. Dr. John H. Trotter, of Morgantown, continues as chairman of the committee on Conservation of Vision and Hearing.

Doctor Watkins has reappointed Dr. Russell C. Bond, of Wheeling, as chairman of the committee on Child Welfare. Dr. Charles L. Goodhand, of Parkersburg, heads the Committee on Maternal Welfare.

The personnel of the committee on Child Welfare, elected at the annual meeting at White Sulphur Springs in August, is as follows:

Henrietta L. Marquis, Charleston; Raymond M. Sloan, Huntington; Carl E. Johnson, Morgantown; Harlow Connell, Bluefield; A. A. Shawkey, Charleston; and Theresa O. Snaith, Weston.

The committee on Maternal Welfare is composed of the following: M. B. Williams, Wheeling; Charles S. Mahan, Morgantown; J. E. Page, Clarksburg; E. J. Humphrey, Huntington; E. W. McCauley, Bluefield; and W. E. Hoffman, Charleston.

Program Committee

The Scientific Work Committee, appointed by the late Russell B. Bailey, M. D., president elect, and renamed by Doctor Watkins, is composed of J. P. McMullen, Wellsburg, chairman, and Richard E. Flood, Cove Station, Weirton, and E. J. Van Liere, Morgantown. The committee is already at work on the program for the 83rd annual meeting at White Sulphur Springs, July 27-29, 1950.

Publication Committee

Members of the Publication Committee are elected by the Council. The Committee at the present time is composed of Dr. Walter E. Vest, Huntington, chairman, and Drs. E. J. Van Liere, Morgantown; William M. Sheppe, Wheeling; G. G. Irwin, Charleston; and R. H. Edwards, Welch.

Standing Committees

The following is a complete list of other standing committees appointed by Doctor Watkins:

Cancer: Philip W. Oden, Ronceverte, Chairman; Chauncey B. Wright, Huntington; Thomas Bess, Keyser; Harry C. Fleming, Fairmont; V. L. Peterson, Charleston; and M. L. Hobbs, Morgantown.

Revision of Constitution and By Laws: Sobisca S. Hall, Clarksburg, Chairman; R. A. Updike, Montgomery; Ben W. Bird, Jr., Princeton; W. T. Booher, Wellsburg; and W. W. Huffman, Gassaway.

DPA Advisory: Hugh A. Bailey, Charleston, Chairman; H. M. Beddow, Charleston; and T. Kerr Laird, Montgomery.

Fact Finding and Legislative: D. A. MacGregor, Wheeling, Chairman; Frank V. Langfitt, Clarksburg; Ward Wylie, Mullens; Russell Kessel, Charleston; Thomas L. Harris, Parkersburg; J. N. Jarrett, Oak Hill; and R. P. Daniel, Pemberton.

Industrial Health: J. J. Brandabur, Huntington, Chairman; A. J. Villani, Welch; DeWitt Peck, Montgomery; F. C. Goodall, Princeton; and George O. Nelson, Nitro.

Medical Education: Bert Bradford, Jr., Charleston, Chairman; E. J. Van Liere, Morgantown; Thomas Bess, Keyser; Jack T. Gocke, Clarksburg; J. C. Huffman, Buckhannon; and J. M. Brand, Chester.

Necrology: R. R. Summers, Charleston, Chairman; C. B. Pride, Morgantown; Upshur Higginbotham, Bluefield; F. L. Banks, Beckley; and B. F. Puckett, Oak Hill.

Public Relations: Frank J. Holroyd, Princeton, Chairman; James S. Klumpp, Huntington; John F. McCuskey, Clarksburg; A. R. Lutz, Parkersburg; Clark K. Sleeth, Morgantown; and Francis J. Gaydosh, Wheeling.

Syphilis: N. H. Dyer, Charleston, Chairman; C. A. Hoffman, Huntington; R. O. Halloran, Charleston; W. Carroll Boggs, Wheeling; and Frank S. Harkleroad, Beckley.

Tuberculosis: W. P. Bittinger, Summerlee, Chairman; William L. Cooke, Charleston; George F. Evans, Clarksburg; Hugh S. Edwards, Beckley; G. R. Maxwell, Morgantown; and A. L. Starkey, Hopemont.

Conservation of Vision and Hearing: John H. Trotter, Morgantown, Chairman; T. U. Vermillion, Beckley; S. H. Burton, Weston; T. W. Moore, Huntington; and A. C. Chandler, Charleston.

Special Committees

Personnel changes in four of the special committees have been made as follows:

Diabetes: George P. Heffner, Charleston, Chairman; O. D. Ballard, Van; F. R. Whittlesey, Morgantown; William A. Thornhill, Jr., Charleston; and W. E. Bundy, Jr., Oak Hill.

Mental Hygiene: Edward F. Reaser, Huntington, Chairman; W. B. Rossman, Charleston; O. N. Morison, Charleston; A. L. Wanner, Wheeling; E. L. Gage, Bluefield; and C. A. Zeller, Weston.

Permanent Home: Paul P. Warden, Grafton, Chairman; P. A. Tuckwiller, Charleston; Philip Johnson, Fairmont; James G. Ralston, Clarksburg; J. H. Wolverton, Jr., Piedmont; and J. D. Romino, Fairmont.

Veterans Board of Review: Ralph J. Jones, Charleston, Chairman; H. M. Escue, Charleston; and James R. Brown, Huntington.

The personnel of the following special committees remains the same: Short Form Insurance Reports; Nurses' Liaison; WVU Liaison; State Blood Bank; VA Investigating; Hospital Relations; UMW Advisory; and Emergency Medical Service.

Woman's Auxiliary Advisory Board

The Woman's Auxiliary Advisory Board heretofore named for 1949-50, is composed of Elizabeth McFetridge, Shepherdstown; W. A. Thornhill, Jr., Charleston; Frank J. Holroyd, Princeton; Paul L. McCuskey, Parkersburg; and E. L. Starcher, Logan.

CLINIC MANAGERS AT THE GREENBRIER

The annual meeting of the National Association of Clinic Managers of 1950 will be held at the Greenbrier, White Sulphur Springs, November 9-11, 1950. Mr. John H. Clark, manager of the Wheeling Clinic, is president elect of the organization and is a member of the committee arranging the program for the meeting.

DOCTOR MacDONALD HONORED

Dr. K. G. MacDonald, of Charleston, has been elected a diplomate of the American Board of Surgery.

AMERICAN MEDICAL ASSOCIATION MEMBERSHIP DUES $25 FOR 1950

A record attendance of doctors at the 3rd Clinical Session of the American Medical Association held December, 6-9, 1949, at Washington, D. C., helped make the meeting probably the best of the three that have been sponsored by the AMA. A total of 3,942 doctors were registered during the first three days of the meeting. The overall registration was 7,631 as compared with 5,497 for the four days of the 1948 meeting in St. Louis.

An interesting and colorful technical exposition was provided in the National Guard Armory, where scientific exhibits were unusually good. There were 142 technical exhibits, as compared with 117 at St. Louis.

AMA House of Delegates

All the sessions of the House of Delegates were held before packed houses. The matter of the assessment of dues for the first time in the history of the AMA is probably responsible for a full attendance of the members at all the sessions.

Never before in the history of the Association have dues of any kind been required. Previously, membership in the AMA was automatic when a doctor became a member of his local society, which also carried with it membership in his state medical association.

A special assessment of $25.00 was levied by the AMA against all members in 1949 to provide funds for its National Educational Campaignn. The payment of this assessment was not mandatory, yet about 80 per cent of the members had paid the assessment as of December 1. The total amount collected was $2,350,000.

Dues $25 For 1950

As this issue of The Journal goes to press, the "blueprint" for the collection of AMA dues had not been received by the West Virginia State Medical Association. It is probable that secretaries and treasurers of local societies will be asked to collect the dues from their members and remit to the secretary of the State Medical Association for transmission to Chicago.

The vote taken at the final session of the House of Delegates was unanimous in favor of the assessment of $25.00 dues per member for 1950.

Fellows of the American Medical Association, will be required to pay an additional $12.00 fellowship dues, and the subscription to The Journal for doctors who are not fellows will remain at $12.00 per annum. At the present time there are 142,000 active members of the American Medical Association, of which number 74,000 are fellows. Including fellows, there are 137,000 subscribers to the Journal of the American Medical Association.

Vote of Confidence

The House of Delegates went on record in opposition to bills pending in Congress which would provide federal aid to medical schools. The bills will be opposed in their present form as it is thought that they give the government too much control over the operation of the institutions.

The House also voted to ask the Defense Secretary for a full report on the status of civilian defense plans, including medical care provisions.

The House also unanimously extended a vote of confidence in the AMA National Education Campaign against federal intervention in health insurance.

American Legion on Firing Line

George N. Craig, of Brazil, Indiana, national commander of the American Legion, was a guest speaker at the final session of the House of Delegates. He assured the American Medical Association of the American Legion's strong support in its fight against compulsory health insurance. He said that federal security administrator Oscar R. Ewing, and other advocates of the federal health plan should be told, "We have just begun to fight."

Continuing, Craig said, "We have achieved the highest medical standards in the world. The American Legion recognizes an urgent need for even greater advancement of the Nation's health services. We want to join with and be joined by the doctors of the country in bringing about necessary adjustments."

General Practitioner of the Year

Dr. Andy Hall, 84-year old general practitioner of Mt. Vernon, Illinois, was named the "general practitioner of the year," and awarded a gold medal for having rendered "exceptional service to his community." Doctor Hall has practiced in Mt. Vernon since 1890, except for the time of his service in the Spanish American War, and as state health director.

Dr. Walter E. Vest, of Huntington, and Dr. Ivan Fawcett, of Wheeling, West Virginia delegates to the AMA House of Delegates, were in their seats at all of the sessions.

Doctor Fawcett completes 12 years' services as a member of the House of Delegates on January 1, 1950. He will be succeeded by Dr. George F. Evans, of Clarksburg, who was in Washington and also attended the sessions of the House of Delegates.

The following West Virginia doctors were registered at the meeting to and including Thursday afternoon, December 8:

Aldis, Henry	Shepherdstown
Appleby, George S.	Martinsburg
Bower, Joseph S.	Martinsburg
Brantley, Clayton	Martinsburg
Brown, Donald P.	Kingwood
Engelfried, C. H.	Charleston
Evans, A. G.	Fairmont
Evans, George F.	Clarksburg
Fawcett, Ivan	Wheeling
Howell, Harold H.	Madison
Hudgins, A. P.	Charleston
Irwin, G. G.	Charleston
Johnson, W. P., Jr.	Masontown
Johnston, William W.	Martinsburg
Kilmer, John H.	Martinsburg
Kingsley, Joyce W., Jr.	Martinsburg
Maecubbin, H. P.	Martinsburg
Malament, Maxwell	Martinsburg
Marks, A. Robert	Clarksburg
McIntyre, Donald K.	Bolivar
Moore, M. A.	Montgomery
Polsue, Wm. C.	Charleston
Poneman, Harold A.	Martinsburg
Post, Cecil O.	Clarksburg
Power, Curtis G.	Martinsburg
Ritchey, Hardin	Harrisville
Schook, Percy E.	Martinsburg
Skaggs, Henry O.	Montgomery
Swepston, Emil R.	Martinsburg
Taylor, Ingram C.	Martinsburg
Vest, Walter E.	Huntington
Wanger, Halvard	Shepherdstown
Wise, S. D. H.	Parkersburg
Zepp, E. Andrew	Martinsburg
Zintek, S. S.	Martinsburg

IMPROVEMENT IN "RIM COUNT" TECHNIQUE

The State Health Department is placing greater emphasis upon the importance of sanitation in public eating places, and the West Virginia Medical Center in South Charleston was recently the "testing ground" for a study to determine the actual efficiency of mechanical dishwashing equipment commonly used in eating establishments.

A portable recording thermometer, recently added to the equipment of the State Health Department was used. The thermometer provides a graphic picture of the time and temperature to which each tray of dishes is subjected in a washing operation.

Frequent outbursts of illness from food infections and poisoning have been traceable to dinners and banquets, and there is no doubt that many undetected cases occur affecting individuals or small groups dining in public places.

Routine in the work of the trained sanitarian in West Virginia is checking the bacterial cleanliness of silver, drinking glasses, etc. by the "rim count" technique. The number of bacteria present can be determined by means of a standardized laboratory procedure.

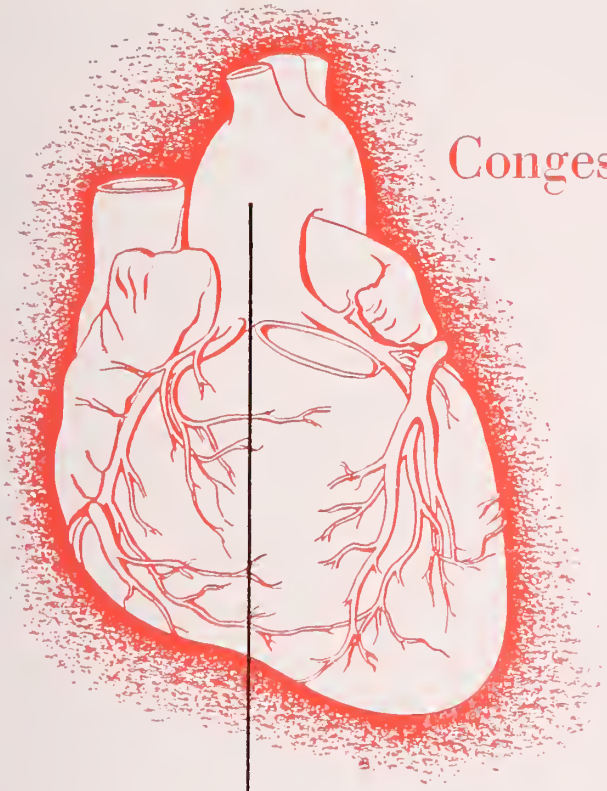
The use of laboratory tests and new testing equipment gives the modern sanitarian definite advantage over his predecessor in that he does not now have to depend upon "superficial observation" to determine the presence of disease-spreading germs.

Information obtained from studies made with the new recorder will be used to educate the owners of public eating places in West Virginia concerning the need for properly designed and operated dishwashing equipment.

SCHERING TAX GUIDES AVAILABLE

The "Schering Physicians' Income Tax Guide for 1950" is a new and up-to-the-minute edition of the popular compilation of information on how to prepare the doctor's income tax declaration and return. It is now being distributed free on request to the Medical Service Department of Schering Corporation, Bloomfield, New Jersey, according to Dr. John N. McDonnell, Schering's vice president.

Designed to meet the need of busy Practitioners, every possible situation in the proper completion of income tax returns is covered clearly and concisely. It provides authoriatative answers for everything from general tax return procedure to such problems as bad debts or the deductibility of reading matter for the physician's waiting room.



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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Howarth, S.; McMichael, J., and Sharpey-Schafer, E. P.: The Circulatory Action of Theophylline Ethylene Diamine, Clin. Sc. 6:125 (July 17) 1947.

OBITUARIES

ERNEST H. BALL, M. D.

Dr. Ernest H. Ball, 61, of Charleston, died at his home in that city, November 27, 1949, of heart disease. He had been ill for about ten days.

Doctor Ball was the son of the late Rev. and Mrs. B. F. Ball, of Charleston. He received his M.D. Degree in 1909 from Maryland Medical College, Baltimore. He was licensed to practice in West Virginia following his graduation, and was located at Quincy for a short time before moving to Charleston.

Besides his widow, he is survived by a brother, Cecil Ball, and four sisters, Mrs. Glenna Casdorph, Mrs. Gladys Sherer, Mrs. Blondena Kock, and Mrs. Helen Layne, all of Charleston.

* * * *

VIRGIL LEWIS CHAMBERS, M. D.

Dr. Virgil Lewis Chambers, 54, of Huntington, died of coronary occlusion, November 30, 1949.

Doctor Chambers was born in Raleigh county. He received his M.D. Degree at the University of Louisville School of Medicine in 1926. After serving internships at St. John's Hospital in Cleveland and Louisville City Hospital, he was licensed to practice in Kentucky in 1926, and was licensed in West Virginia by reciprocity with that state in 1928. Doctor Chambers practiced for a few months in Louisville before moving to Huntington, where he continued in active practice until his death.

He was always an active Scout worker, and was the first Boy Scout in West Virginia to receive a Scout medal for saving a boy from drowning.

Doctor Chambers served for 18 months as a member of the Medical Corps of the Army during World War I. He was a member of the Cabell County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Besides his widow, he is survived by two children.

* * * *

JAMES KUYKENDALL GUTHRIE, M. D.

Dr. James Kuykendall Guthrie, 62, of Martinsburg, died December 5, 1949, while deer hunting on a farm near Romney. When he had failed to return home late that evening, a searching party was organized, and his body found on a farm early the following morning. Death was attributed to a heart attack.

Doctor Guthrie was born at South Branch, West Virginia, and received his academic education at Washington and Lee University, graduating with a B.S. degree in 1908. He received his M.D. degree in 1912 from the College of Physicians and Surgeons, Baltimore.

After practicing for some time in Iowa, Doctor Guthrie took postgraduate work in EENT in 1919-20, after which he located at Martinsburg, where he continued in active practice until his death.

He was a member of the Eastern Panhandle Medical Society, the West Virginia State Medical Association, and the American Medical Association.

* * * *

CHARLES FRANCIS MAHOOD, M. D.

Dr. Charles Francis Mahood, 71, of Alderson, died at his home in that city December 14, 1949, following a long illness.

Doctor Mahood received his M.D. Degree at the University College of Medicine, Richmond, in 1901, and was licensed that same year to practice medicine in West Virginia. His specialty was EENT, and he had been actve in practice at Alderson since 1915.

He served as a member of the Army medical corps during World War I.

Doctor Mahood had served as president, secretary, and treasurer of his local medical society, and had also served as city health officer and a member of the council of his home city.

Besides his widow, Mrs. Margaret (Conner) Mahood, he is survived by a daughter, Mrs. Kathleen Mahood Barker, of Charlotte, North Carolina, and two sisters, Mrs. Grace M. Carwile and Mrs. Val M. Beall, both of Oak Hill.

DR. VAN LIERE ON PROGRAM IN PERU

Dr. Edward J. Van Liere, of Morgantown, dean of West Virginia University School of Medicine, was a guest speaker at a World Symposium on High Altitude Biology, in Lima, Peru, November 23-30, 1949. The Symposium was held under the auspices of UNESCO and the government of Peru, and eighteen countries were represented.

Doctor Van Liere's subject was, "Some New Criteria of Acclimatization to Altitude." While at the meeting, he presided over a session devoted to the subject of "Adaption to Chronic Anoxia."

Doctor Van Liere traveled by air to and from Lima, and was out of the country for about two weeks.

DR. DAVISSON HONORED BY ACADEMY

Dr. C. R. Davisson, of Weston, a diplomate of the American Board of Ophthalmology and Otolaryngology, has been elected to fellowship in the American Academy of Ophthalmology and Otolaryngology. This honor was conferred upon him at the annual meeting in Chicago a few weeks ago.

GOLF AND TENNIS TOURNAMENTS

The committee arranging for the 83rd annual meeting of the West Virginia State Medical Association at White Sulphur Springs, July 27-29, 1950, has made a place on the program for golf and tennis tournaments, and Dr. Charles E. Watkins has appointed committees to make the necessary arrangements.

Dr. R. R. Summers, of Charleston, heads the golf tournament committee and the other members are Drs. Olan T. Coffield, of New Martinsville, and R. O. Halloran, of Charleston.

Dr. Spencer L. Bivens, of Charleston, is chairman of the tennis committee, and the other members are Drs. Robert M. Biddle, of Parkersburg, and John Lutz, of Charleston.

COUNTY SOCIETIES

B-R-T

The scientific program at the November 17th dinner meeting of the B-R-T Medical Society, held at the Tygarts Valley Country Club in Elkins, consisted of a panel discussion on Gallbladder Disease. The panel was composed of Drs. L. D. Zinn, internist, Clarksburg, E. E. Myers, clinical pathologist, Philippi, Herman Seltz, radiologist, Elkins, and J. E. Wilson, Jr., surgeon, Clarksburg.

A short paper was presented by each member of the panel, and several doctors participated in the round-table discussion which followed.

At the business meeting which followed the scientific program, the following doctors were elected to membership in the society:

R. V. Corton and E. E. Hutton, Elkins; Michael Stump and Cecil Shaffer, Philippi; Robert E. Smith, Parsons; and George W. Duffy, Thomas.—Donald R. Roberts, M. D., Secretary.

* * * *

CENTRAL WEST VIRGINIA

Dr. George D. Hill, of Camden-on-Gauley, was elected president of the Central West Virginia Medical Society at the regular monthly meeting held November 10, 1949. Dr. Worth B. Forman, of Buckhannon, was named vice president and Theresa O. Snaith, of Weston, reelected secretary-treasurer.—Theresa O. Snaith, M. D., Secretary.

* * * *

HARRISON

Dr. John F. McCuskey, of Clarksburg, was elected president of the Harrison County Medical Society at the regular monthly meeting held December 1, in that city.

Dr. Robert T. Humphries, was elected vice president, and Dr. L. D. Zinn, secretary. Dr. C. O. Post was reelected treasurer.

The following doctors were elected members of the Board: James Ralston, R. T. Humphries, George W. Rose, John F. McCuskey, C. O. Post, Linwood D. Zinn, and D. H. Lough.

Drs. S. S. Hall, C. O. Post, and James Ralston were elected delegates to the House of Delegates, and Drs. H. V. Thomas, T. V. Gocke, and Lawrence Mills, alternates.

The folowing resolution was unanimously adopted:

WHEREAS, The President of the United States and various other members of the federal government have seen fit to propose the enactment of compulsory health insurance; and

WHEREAS, The majority of doctors of medicine have interpreted this proposal as meaning the ultimate control of all medical practice by the government, and, through action of the American Medical Association, the West Virginia State Medical Association, and the Harrison County Medical Society, we, as doctors, have in the past expressed our opposition to compulsory health insurance; and

WHEREAS, Registered nurses, individually and collectively, are closely associated with doctors of medicine in the delivering and distributing of medical care; and

WHEREAS, Any legislation which adversely affects the status of doctors of medicine must also equally affect the status of registered nurses:

THEREFORE, BE IT RESOLVED, That the Harrison County Medical Society, Inc., as an organization, and each member individually, severely condemns the recently reported action of the West Virginia State Nurses' Association in failing to take a positive stand against compulsory health insurance at their meeting at White Sulphur Springs, November 5, 1949, when presented with the opportunity to do so; and,

BE IT FURTHER RESOLVED, That a copy of this resolution be sent to the Nurses' Alumni Association of the Union Protestant Hospital; the Nurses' Alumni Association of St. Mary's Hospital; the Nurses' Association of this district; the West Virginia State Nurses' Association; the West Virginia State Medical Associaton; the State Public Relations Chairman; and all County Societies.

MONONGALIA

Dr. Lucien M. Strawn, of Morgantown, was elected president of the Monongalia County Medical Society, at the regular monthly meeting, held in that city, December 6. Other officers were elected as follows: Vice president, Dr. Clark K. Sleeth; secretary, Dr. Maynard Pride; and, treasurer, Dr. C. C. Romine.

The Society went on record as favoring the establishment, at the state level, of a Grievance Committee to deal with complaints of patients or the public concerning individual doctors or groups of doctors.—Clark K. Sleeth, M. D., Secretary.

NEW HYGIENIC LABORATORY BOOKLET

The State Hygienic Laboratory has prepared for distribution a booklet outlining its services and policies. The booklet is designed for the purpose of helping health workers and doctors procure laboratory services.

Concise information is furnished concerning biologicals available, types of containers and means of obtaining them, examination of specimens, week-end services, and other helpful information.

The booklet, "services and Policies of the West Virginia State Hygienic Laboratory," will be mailed to the secretary of each component society of the West Virginia State Medical Association. As changes occur in policy or service offered, revised pages for insertion will be mailed to all persons receiving copies of the booklet.

Doctors may obtain a copy of the booklet for reference purposes by writing to the State Hygienic Laboratory, Charleston 5, West Virginia.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

BOOK REVIEWS

OPERATIONS OF GENERAL SURGERY—By Thomas G. Orr, M. D., Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas. Second Edition. Pp. 890, with 1700 step-by-step illustrations on 721 figures. Philadelphia and London: W. B. Saunders Co. 1949. Price $13.50.

The second edition of Thomas G. Orr's Operations of General Surgery has been considerably revised by means of additions and revisions in every chapter. It remains profusely illustriated, there being 1700 illustrations on 721 figures.

As pointed out by the author in his preface, many new drawings have been added and some of those used in the former edition have been replaced with illustrations of more modern technique. There has been no change made in the chapter arrangements, the book still being arranged according to systems rather than anatomic divisions.

The basic sciences have not been neglected and where necessary, to clarify technical points, a brief description of the anatomy involved is presented. The dangers and safeguards of each procedure are described and these paragraphs frequently make reference to the physiologic principles that must be taken into consideration.

The book remains primarily a volume on surgical technique but should the reader desire to look into the broader aspects of a particular problem, he is aided by an elaborate list of references at the conclusion of each chapter. Regarding tenchique, the author has included those of other surgeons together with his own so that in most instances, multiple methods of management for a particular procedure are well described and illustrated.

The most important additions have been made to the chapters on Congenital Anomalies and the Digestive and Respiratory Systems. These have been brought up to date to include the work of Blalock and Gross on anomalies of the aortic arch and many improved techniques in the fields of gastric and thoracic surgery.

The reviewer does not hesitate to recommend this useful work to both the beginner and the experienced general surgeon.—Melvin E. Lea, M. D.

* * * *

TONICS AND SEDATIVES. Selections from his favorites by Morris Fishbein, M. D. Original drawings by Poge Corey. Pp. 120. The J. B. Lippincott Co., Philodelphio. 1949. Price $2.00.

This attractive little volume contains the favorites culled by Dr. Fishbein during his long editorial career. In the preface, he says that his column, "Tonics and Sedatives," is composed largely of items contributed by physicians and that this fact has given him the opportunity to learn what makes doctors laugh.

Certainly it has been the custom of many members of our profession to read this column first upon arrival of the Journal. It is even hinted that many of the

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(3)	Internal Medicine	March 13-17, 1950
(4)	Surgical Physiology	March 20-24, 1950
(5)	Obstetrics and Gynecology	March 27-31, 1950
(6)	Psychiatry	April 3-7, 1950

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doctors' wives snatch the Journal to read the "funny column" before their husbands have a chance at it. At any rate, Dr. Fishbein characterizes the items contained in this little volume as "the cream of the crop" of jokes and ludicrous notes which he has over the years published in the Journal.

Page Carey's illustrations definitely add attractiveness. The book is neatly gotten up, and the subject matter presents some of that rare ingredient, fun in a doctor's life.

* * * *

A TEXTBOOK OF SURGERY by American Authors. Edited by Frederick Christopher, M. D., Professor of Surgery, Northwestern University Medical School. Fifth Edition. Pp. 1550, with 1465 illustrations on 742 figures. Philadelphia and London: W. B. Saunders Co. 1949. Price $13.00.

This is the fifth edition of a textbook first printed in 1945. There have been numerous advances in the different fields of surgery and an effort has been made to bring the tested and present day principles up to date.

Several new sections have been added and some of the old have been altered. Sections which are new or have been radically changed are:

Chemotherapy of Surgical Infections; Pathology and Repair of Fractures; Fractures of the Femur; Operative Treatment of Fractures; Injury and Surgical Infections of the Eyes; Tumors of the Stomach; Anomalies of the Stomach and Bile Ducts; Aseptic Surgical Technique; and Management of the Surgical Diabetic Patient.

There are many contributors, each of whom is an authority in his branch of surgery. As the name implies, this is a textbook in which the eitology, pathology, diagnosis and operative principles are properly stressed. It does not pretend to offer a detailed discussion of operative technique.—John Lutz, M. D.

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CORRESPONDENCE

VETERANS ADMINISTRATION
Regional Office
824 Fifth Avenue
Huntington 1, West Virginia

December 15, 1949

Mr. Charles Lively, Executive Secretary
West Virginia State Medical Association
Atlas Building
Charleston, West Virginia.

Dear Mr. Lively:

I am writing to request that you bring to the attention of the members of the West Virginia State Medical Association the following matters of mutual interest to them and to the Veterans Administration:

"I drove twelve miles up Lost Hollow twice last month to treat that boy. Now, that Veterans Administration outfit not only refuses to pay, but they say I'll have to pay for the drugs I prescribed."

More than one doctor who is cooperating with the VA under our plan with the West Virginia State Medical Association for out-patient treatment of disabled veterans is going to think he is being quoted on his most recent experience with the VA. The particular statement quoted above is fictional, but it might well have been made by any of several physicians who last month made one error in their dealings with the VA: They did not tell us beforehand.

Except in real emergencies, prior approval for all medical services must be secured in advance. In the case of an emergency, the VA will pay if authorization is obtained within 15 days in the case of out-patient treatment or within 72 hours for hospitalization.

Frequently, we have the problem in which, for example, four office visits have been approved for a veteran in December. Perhaps, upon completion of the fourth treatment the physician observed that additional treatment was necessary and called the veteran in for two additional visits. Or, it may be that the veteran did not report for his first treatment until December 19. He was given four weekly treatments, the number authorized, but the third and fourth treatments fell in January. In either case, the physician is going to receive a note from the VA to the effect that he has billed for two unauthorized treatments for which no payment can be made.

We in the Medical Division can readily understand that the doctor was acting in the best interests of the patient. The care was needed, and he gave it. He did not do one thing in his own interest. He did not let us know what was happening until too late.

The physician is a busy man. This affair of prior approval from a third party is outside his usual routine. The fact that it smacks of "red tape" makes it seem even more troublesome.

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If you have given treatment without approval, the guardian of the checkbook will permit us to authorize payment only if the case meets the following four criteria—

1. The condition is service-connected.
2. VA facilities were not available.
3. Delay would have been hazardous.
4. The treatment was rendered in a medical emergency.

All four of these conditions must be met. A note to us or, if the situation indicates, a collect telephone call will save the physician time and money, and we in the VA will be saved much embarrassment.

Payment for drugs and medications is likewise predicated upon authorization. You may write a prescription for the needed drug to your local participating pharmacy. This prescription must bear the legend, "I am authorized to treat this Veterans Administration patient."

Be sure that you write that sentence. The fact that you have on your desk an authorization to treat John Smith does not mean that we can pay for the prescription that you write for his brother, Tom Smith. Even if you gave Tom an authorized treatment last month, be sure you have him on the approved list this month before writing that prescription.

Misunderstandings in this respect have been so general throughout the country that it has become the subject of a ruling by the Comptroller General of the United States. This ruling states that monies expended in payment of prescriptions written when the physician does not hold a current authorization are to be collected from the physician using the VA legend without authorization, or from the veteran if he is not eligible for treatment for the particular condition involved.

Of course, if the four criteria previously mentioned, including that of emergency, are met, payment may be made by the VA despite the absence of prior authority. In no case, however, can the VA pay for medicines used by a physician from his private stock, nor can we replace them.

Without the services of the thousands of physicians throughout the country who have joined with the VA in plans similar to ours in West Virginia, we could not hope to give our disabled veterans the more beneficial, more practical home-town care which they have received.

With each of us, the home-town physician and the VA physician, maintaining an understanding of the other's problems, and of our common problems, I feel certain that we can continue to give our disabled veterans the medical care which they deserve—the best in the world. There is one thing: Let the VA know beforehand.

Very Sincerely,

Leo F. Steindler, M. D.,
Chief, Medical Division.

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Editor
WALTER E. VEST, M. D.
955 Fourth Ave.
Huntington, W. Va.

Managing Editor and
Business Manager
MR. CHARLES LIVELY
Box 1031
Charleston 24, W. Va.

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MEDICAL CARE IN THE ATOMIC AGE*

By HAROLD C. LUETH, M. D.,
Omaha, Nebraska

The liberation of atomic energy has brought rapid changes to the practice of medicine. In 1896 Professor Henri Becquerel discovered that uranium gives off short waves that act similar to x-rays as they are invisible and pass through thin sheets of metal and cloud photographic paper. Later in his work, he noticed a small burn on his chest just beneath the place where he had carried a test tube of uranium in his vest pocket. For their discovery of radioactivity Professor Becquerel and Pierre Curie were awarded the Nobel Prize in 1903.

About twenty-five years ago, the first attempts were made to use stable radioactive tracers by Hevesy who experimented with lead salts in plant growth. As stable radioactive substances were not normal constituents of plant and animal metabolism, work done in this regard was quite limited. In 1932, Irene Curie and Frederick Joliot[1] found ordinary elements could be made radioactive after very high energy nuclear bombardment. This discovery widened experimentation in the fields of therapy, physiology and metabolism. While some preliminary work was done, the tremendous amounts of energy needed in the bombardment machines called cyclotrons or "atom smashers" resulting in the production of very limited amounts of radioactive substances for experimentation, circumscribed the amount of investigative research. Some research was taking place in the field quietly and in a small way during the next ten years.

On December 2, 1942, at the University of Chicago, the first self-maintaining nuclear chain reaction ever initiated by human beings took place.[2] The principle of the operation of atomic fission was simple enough. By suitable bombardment from without by neutrons, ordinary substances could be made radioactive in a cyclotron. If a neutron could be made to split an atom and the split product contain other neutrons that would in turn split other atoms, the amount of atom splitting would be tremendously greater than any produced in the past and enormous amounts of energy would be liberated.

The enlargement of the chain reaction of December 2, 1942 that liberated one-half watt of energy to the atomic bombs of Hiroshima that have been estimated by a former Assistant Secretary of War to be equivalent to twenty thousand tons of T.N.T., is a tribute to the scientific and engineering skill of our people.

After the war, the Atomic Energy Commission, realizing the means it had at its disposal for the production of larger amounts of radioactive substances, turned to the field of biological investigation. Since June 1946, it has made available to competent investigators an increasing number of radioactive products. Studies in the treatment of disease; plant, animal and human physiology, and newer means for diagnosis by isotopes have utilized 70 per cent of all available isotopes supplied by the commission.[3]

Research has been greatly stimulated in many fields following the availability of these new tools of investigation. The impact of atomic en-

*Presented before the 82nd Annual Meeting of the West Virginia State Medical Association, at White Sulphur Springs, August 5, 1949

ergy on our civilization is so great that all physicians must be familiar with its implications on the health and welfare of the nation.

Some estimate of the discoveries from the results of the atomic bomb may be gained from the following picture. Think of a moderately large city with its normal business activity and the havoc and confusion that would follow if an atomic bomb were dropped on it. All persons living within a radius of about two-thirds of a mile would be killed instantly. A central core of destruction would be an area of 4.4 square miles with a maximum radius of 2 miles.[4] In an outer zone approximately five miles in diameter many people would be killed by blast, burns, or flying missiles. Flash burns would occur on persons up to 11,000 feet from the center of explosion.[4]

Communications and transportation facilities would stop immediately after the explosion and the roads leading to the area would be crowded with refugees. Many small fires would gain headway and burn areas in the city not initially burned. Medical, nursing and hospital services would be suddenly overwhelmed. Fire fighting services would be helpless as difficulties in removing equipment and the low water pressure would make them inoperative. This is essentially what took place at Hiroshima and Nagasaki.

The physical effects of the atom bomb are of great interest to the medical profession as they indicate the types of casualties likely to be encountered.[5] After the detonation of an atomic bomb there is tremendous release of energy as manifested by pressure, heat and radioactivity. There are four main effects: blast, heat or thermal effects, radiation and psychologic effects.

The effect of blast is well known and has been adequately described. The tremendous pressures that develop after detonation are like a very high wind traveling at the rate of 75 to 200 miles an hour. Blast operates over a short period of time and causes death, compression of the lungs and abdominal viscera. Nearer the center of the discharge bodies show signs of violence, avulsion of the limbs or complete disintegration.[6] Experiments performed as a part of Test Able showed that about 10 per cent of the 35,000 animals including goats, pigs, guinea pigs, mice and albino rats held captive on the tragic ship were killed almost instantly from heat or blast or both.[7]

Heat or Thermal Effects.—In all explosions the sudden release of energy is in part converted into heat and produces enormous temperatures in the surrounding air. In the initial Los Alamos project the heat generated by the atomic explosion crumbled and melted steel towers into liquid.[8] It is believed that about one-third of the population within the radius of an atomic bomb is killed instantly by heat and blast.[7]

Many persons received deep thermal burns. Clothing absorbed or reflected heat depending upon the nature and color of the material. Colored or black cloth absorbed heat and caused burns, while white clothing worn by people reflected the heat. Heat waves travel at the speed of light. Exposure to intense heat for a few thousandths of a second is enough to cause a burn. Dr. Stafford Warren[9] described the protection afforded an asphalt bridge by the shadow of the concrete posts and side railings. Concrete side railing were sufficient to absorb the intense heat of the bomb at Hiroshima so that the asphalt was not melted over the areas of their shadows. Minor and severe burns were frequently encountered among the inhabitants of the two cities of Japan. Severe burns — either thermal or gamma radiation — resulted in early death. It is not always possible to differentiate between the two and the same type of treatment is initially indicated for both.[10] A number of severe burns of the face and hands were encountered and ears were not infrequently burned off. Dark clothing and dark hair often absorbed enough heat to result in severe burns even though the exposures were very short. A number of cases showed distinct margins indicative of the protective or harmful effect of clothing. Black cross straps worn over the white shirts of Japanese policemen frequently resulted in deep burns beneath the straps that stood in sharp contrast to the remaining untouched skin over the back.

Release of Ionizing Radiation.—The atom bomb releases split or fission products, many of which are unstable isotopes which continue to emit beta particles and gamma rays in huge amounts. At first the activity of these isotopes is exceedingly high; however, since many of them have short half-lives they disappear rapidly.[11] At the end of the first hour there is a steadily decreasing rate of intensity called the decay rate of the gamma rays. This intensity is inversely proportional to the time after detonation. Depending upon the type of bomb used, the radioactive material is mixed either with the hot gases that rise as a plume over the bombed area or are contained in the water spray that is raised as a result of the underwater detonation.[12]

Fission materials are a real problem. These are the very small particles that may adhere to dust or may be mixed with water droplets, hence radioactive clouds become a problem.[2] The rate of settling out of the mist is to a large extent determined by the size and composition of the particles and the effect of gravity on these particles. Neutrons, as they are broken off at the time of detonation, strike materials on the

ground and in the water and contaminate these areas. Sodium, phosphorus and iron are readily attacked by radioactive split products. For example, in the Bikini experiments it was found that ordinary soap, because of its sodium content, would retain neutrons and carry significantly high quantities of radioactive material. Ordinarily, the neutron activity of aerial atom bombs on the ground below is not much of a hazard by the time that rescue squads or disaster personnel get in the area, because the half-lives of radioactive material are relatively short.[13] After an underwater detonation, the situation is different. Water surrounding the atom bomb absorbs gamma radiation and neutrons contaminating the region, constituting problems of real concern.[7] A large quantity of water is mixed with the radioactive fission material and usually is quite concentrated. When the water is thrown relatively high in the air by the force of the explosion, the radioactive material, instead of being dispersed widely as in the case of aerial explosions, is more concentrated in a small area.

Conservative estimates conclude that the amount of fission material available in an underwater test as measured in gamma radiation, may be equivalent to that given off by tons of radium. Fish caught in the waters of the lagoon of Bikini had absorbed enough radioactive material that when held against sensitive paper they made autoroentgenograms. In other words, the fish made its imprint from its own radioactivity.[14]

Radiation sickness follows a well known pattern.[10,15,16,17] All cells exposed to radioactive substances begin to show changes. Gamma rays injure living cells by ionization. Shields Warren[16] has estimated that a fatal dose of radiation is in the neighborhood of 500 roentgen units. Gamma radiation apparently interferes with the metabolism of the cells; the more active the cells, the more readily affected. It is presumed to affect the nucleic acid metabolism of the cell.[16] Jacobson, Stone and Allen[10] have estimated that the effect from radiation follows a fairly definite pattern. Exposure of 50 to 200 roentgen units results in slight nausea, mild leukopenia and thrombopenia with ultimate recovery of the patient. Exposure of 200 to 400 roentgen units results in severe leukopenia, thrombopenia, transitory anemia, severe nausea, vomiting, diarrhea and hemorrhagic manifestations. Most patients would recover, but a relatively small per cent of persons exposed to these amounts of radiation would die.

Exposure of 400 to 600 roentgen units results in serious illness, anemia, leukopenia and hemorrhage, and even with the best forms of supportive therapy about 50 per cent of the patients would die.

Effects on the hematopoietic system are well marked and furnish a good clue to the amount of radiation.[17,18] The changes in the gastrointestinal tract, particularly the intestinal mucosa, the mouth and tonsils are well known.[19] Stomatitis and ulceration of the tonsils result in a picture resembling Ludwig's Angina that was not uncommonly seen at Hiroshima and Nagasaki. Intestinal lesions were mainly the disintegration of the lymph nodes in the intestines and the sloughing of the intestinal mucosa. Diarrhea, abdominal pain and intestinal hemorrhage were frequently observed. Many patients suffering from these lesions died within three weeks from the time of exposure. The sex glands also show marked changes, particularly in the male with impotence and sterility and in the female with suppression of the menses.[7,16]

The whole question of genetic changes following the explosion of the atomic bomb is one that will take considerable time for its solution. Doctor Neel is making a special study of this for the Committee on Atomic Casualties of the National Research Council as established by the President. It was pointed out by Doctor Neel that considerable knowledge must be gained concerning the number of defects such as stillbirths, live births with external abnormalities, and internal defects occurring among the Japanese civilian population prior to the bomb before any comparisons can be made with the populations exposed to the bomb in the two cities. From previous experiments it is known that changes in dominant traits are more significant than alterations in recessive characteristics. It will take at least another 25 years and a new generation before the final answer can be given on the genetic changes of the dominant traits of the population exposed to the atomic bomb.

Soon after the bomb was dropped there were exaggerated reports of monstrosities and abortions occurring in the population. Dr. Shields Warren[13] reviewed the Nagasaki survivors as seen in 1947 two years after the bomb had been exploded. He reported that in 1945 a considerable number of survivors showed disturbances of the hematopoietic system and that by 1947 most survivors had returned to normal. Sternal punctures among the population suggested increases in monocytes and reticular cells. There were many scars from flash burns and some keloid formations as residual effects of the bombs. It is believed that keloid formations are more common among the Japanese race than among the white race and there is little evidence to support the contention that the atomic bomb was responsible for keloid formations. Neither

is there any indication that the atomic bomb has been responsible for an increased number of abortions or monsters in the population living in Hiroshima or Nagasaki.

Psychologic Effects.—A weapon of the great potentiality of the atomic bomb is the definite psychologic threat that it carries. Reactions of the population will be varied and will depend upon the experience, training and conditioning of the persons concerned.

Those persons who have heard only the gruesome results of the bomb will be definitely depressed by the possibility of the threat of immediate death. Anxiety and fear will be kindled in the minds of those who do not understand the bomb. The fear of immediate death is not the only factor but the possibility of lingering illness with no prospect of recovery constitutes a real anxiety for the majority of the people.

It will be the task of the medical profession to help reassure the population that steps can be taken to minimize the effect of the atomic bomb and to provide help for persons outside the zone of central destruction.

Another aspect of the problem is teaching proper respect for gamma radiation. It has been the experience of those handling fission products that after a certain length of time carelessness develops. The potentialities of destruction from these invisible rays make it mandatory that all who handle them or are exposed to them exercise eternal vigilance. The health record of the Manhattan Project during the development of the bomb and the absence of any serious health hazards among the workers are indications of what can be done under proper training and supervision.

The Bikini experiments[12] with 60,000 participants at which time two bombs were dropped, the aerial bomb, Test Able, and the underwater detonation, Test Baker, without a single person suffering from radiation sickness emphasized the value of proper training and strict supervision.

In the early days of radium and x-ray, many physicians received severe burns largely because so little was known concerning the handling of these agents. With the ready availability of good means of detection such as the Geiger-Mueller Counter, Ionization Chambers, Pencil Electroscopes and Photographic Badges there is no excuse for injuries from radioactive substances.

To meet the problems of atomic bomb casualties requires comprehensive, well integrated programs, far in advance of any contemplated bombing. Considerable thought and energy have been given the problem, and Russell J. Hopley,[21] Civil Defense Officer for National Security, has developed an excellent program that was issued on October 1, 1948, which furnishes a blueprint for coordinating community defense against the bomb. Medical and health services contained in the report were well defined and presented by Colonel Perrin H. Long.

Some of the major problems in meeting an atomic bomb attack would include: the developing of facilities in the outskirts of larger cities for adequate hospital care, the proper treatment of ambulatory casualties for emergency rations and for shelter. A concentric ring of installations of this type about the larger cities, particularly the industrial cities, would be the most likely way of insuring continuous medical and health services.

A second feature should be the construction of large reinforced concrete air raid shelters placed deep underground.[4] Results of the underwater detonation, Test Baker, showed that considerable protection could be afforded against blast and heat by the use of secure shelters.[7] These shelters do not entirely protect against effects of radiation, and special precautions must be employed to meet these objectives.

Thirdly, there must be available workers throughout the bombed areas to act as rescue teams, stretcher bearers, aid station personnel and supplementary nursing personnel similar to the plan worked out so admirably by the British during the blasts of World War II.

Provision must be made to have a sufficient number of persons on hand to determine the center of the bombed area and to plan for the safe distances of radiation.[10] There must be a sufficient group of trained monitors to determine safe areas and to check all existing facilities. Evacuees, sick, and wounded personnel must be screened for contamination, since they are likely to disseminate radioactive material in the aid stations and clearing stations in the hospitals.[4]

Dr. A. A. Bauer[22] has pointed out the tremendous number of casualties that will be found immediately after an atomic bomb explosion and urges enactment of a community-wide tetanus toxoid program to prevent tetanus from developing among the wounded. Immunization programs against the typhoid group of organisms should be carried out also, as there is a possibility of sewage contamination. A system of pretyping of the population with a means of having everyone carry known identifications of the blood type would make it possible to procure blood on a large scale and to give blood more expeditiously. Adequate stores of antibiotics and whole

blood for transfusions and intravenous medications are essentials to a sound medical program. Availability of good nursing care through the use of large numbers of personnel is also a necessity.

The American Medical Association has become concerned with the situation, and in December 1945, directed a study of the overall needs and utilization of medical skills and resources in the event of a national emergency. A Council on National Emergency Medical Service was created by the Association and a large number of state medical associations have formed similar groups. There is great interest in the problems and much has been done in the planning for an eventuality. The Council on Physical Medicine has prepared two excellent publications entitled: "Glossary of Terms Used in Atomic Energy and Nuclear Physics,"[23] and "Primer of Questions and Answers Relating to Medical Applications of Atomic Energy."[24] These are helpful in acquainting the physician with the problems of atomic energy.

The effects of the atomic bomb may seem appalling to many persons because of the extensive destructiveness, death and disability. When the beneficial effects of phosphorous (P 32) and the cure of polycythemia vera, Iodine 131, in the treatment of hyperthyroidism and carcinoma of the thyroid, Sodium 24 in the treatment of lympomas and leukemias and in the diagnosis of peripheral vascular diseases are considered, a much more hopeful aspect of atomic energy is gained.[3,7,10,23]

Promising results have been reported from Gold 193, Manganese 54 and colloidal forms in the treatment of leukemia, and radioactive cobalt in the treatment of bone tumors.[25] The great developments in the study of cellular metabolism through tracer elements is a field scarcely touched.

We are first beginning to know how much of the cell was developed originally and how much is being replaced by metabolism. All of these results indicate that out of the ashes of Hiroshima and Nagasaki there will come a beneficial atomic energy that will rise phoenix-like to benefit the health and welfare of our nation.

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MYSTERY OF PERNICIOUS ANEMIA UNFOLDS

With the discovery of folic acid, vitamin B_{12}, and related anti-anemia material, the final conquest of pernicious anemia through nutrition research has been accomplished. The discovery of these compounds and their mode of action has also shed considerable light on the probable mechanisms involved in the production of this disease. It is quite likely, therefore, that research with these new nutrition tools will completely clarify the century-old mystery of the biochemical nature of pernicious anemia, its causes and cure, in the very near future.—Ruth Woods in Borden's Review of Nutrition Research.

PYRANISAMINE MALEATE, ITS USE IN TREATMENT OF THE COMMON COLD IN YOUNG CHILDREN*

By JOHN M. BREWSTER, Captain (MC) U. S. N.,
and
THOMAS A. ANDERSON, JR., Lieutenant (JG) (MC) U. S. N.†

The common cold, when attacking the very young, is a more serious disease for the parents than for their children. To be sure it is not the disease *per se* but the knowledge that serious complications so frequently intervene which generates the heavy burden of anxiety. Following an experience with an attack of acute otitis media, mastoiditis or croup in their child the young parents live in dread of future colds. The discovery of the sulfonamides and, later, penicillin and other antibiotics provided a means of preventing and rapidly curing the serious complications. However, until recently, nothing had been found either to prevent or to abort colds or even to meet satisfactorily for sufficiently sustained periods, the distressing symptoms of nasal obstruction, or rhinorrhea, or the insistent hacking cough of the resulting acute laryngitis.

One of us first noted in 1946[1] that a few milligrams of one of the then available antihistamine drugs, when mixed with a little sugar and given to his son at bedtime, gave both his young son and himself a wonderful night's sleep. Furthermore, it was subsequently observed that the child's colds became shorter in duration and that complications arose less frequently when this treatment was used promptly. The use of this particular variety of antihistamine drug, because of its very pronounced soporific side-effect, had to be limited in most cases to bed patients or for use as a night dose in ambulatory cases.

Experience in a large series of cases in adults[2] later demonstrated that a high percentage of colds could be eliminated or aborted if the medication was begun at the onset of the cold and the effect of the drug was maintained without interruption for a period of twelve hours. In searching for an adequate explanation for this phenomenon, the theory was evolved that the common cold originates as the result of or rather as a complication of an allergic reaction manifested in the mucous membrane of the upper respiratory tract acting as the shock organ. With this concept the abortion or prevention of colds can be understood as resulting from the interruption of the allergic reaction accomplished when the causative agent, histamine or a histamine-like substance, is blocked before the virus of the common cold has penetrated the respiratory mucous membrane in any quantity. It also explains the reduction in complications. With prompt return of the mucous membrane to normal, it becomes impervious to the attack of pathogenic organisms which, therefore, must remain harmless on its surface (the normal state).

Subsequent research disclosed that the conviction that allergy was a factor in many colds had been expressed by medical observers[3, 4, 5] for a number of years. Troescher-Elam[6] and her coworkers demonstrated the presence of histamine in nasal secretions of patients suffering from the common cold. Fox and Livingston,[7] in a recent publication, cover the subject exhaustively. Our concept of the role of allergy in the genesis of the common cold was evolved from experience with the antihistamine agents which are specific in their action of blocking histamine and which were not available to the early workers in this field.

It was during the study of this second series of cases that it was found that N-p-methoxybenzyl-N-dimethyl-aminoethyl-a-amino-pyridine (pyranisamine maleate) was effective in the treatment of colds and furthermore that it produced little or no soporific side-effect in most patients. Largely at our request a preparation of this drug in a vehicle of pleasantly flavored syrup was developed, containing 2.5 mg. of the drug per cc. for use in infants and young children. A satisfactory dosage level was then cautiously developed.

Without notice a series of cases was quietly run during the winter of 1948-1949 at the Dependents' Clinic of a U. S. Naval Hospital, with the syrup of pyranisamine maleate as the sole treatment for the common cold in a selected group of young children whose parents agreed to the plan. All patients chosen for the series were given a thorough physical examination.

To eliminate possible confusion with hay fever, the cases were chosen when colds were most prevalent among adults in the community. The presenting sign in all accepted cases was an acute coryza with or without a secondary cough. The medication was issued in one or two ounce quantities with instructions to the mothers to give one teaspoonful in the morning, another in the afternoon and 1½ teaspoonfuls at bedtime. They were asked to return their children at the end of two to four days unless a complication made an earlier check advisable.

There were 93 cases in the series, the youngest patient being 1 year old and the oldest 5 years. The duration of symptoms prior to appearance at Clinic, as observed and related by the mother,

*This study was conducted on the initiative of the senior author and was not an authorized research project under the auspices of the Bureau of Medicine and Surgery of the Navy Department. The opinions expressed in this article are those of the writers and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

†Resigned July, 1949.

varied from eight hours to seven days. The average patient had been sick eighteen hours.

RESULTS

The results were as follows:

Complete cessation of symptoms with return to normal of the mucous membrane of the nasopharynx	65%
Improved but not entirely cleared	10%
No improvement	25%
Number of cases in which parents were pleased	71%
Number of cases in which parents were dissatisfied	26%
Number of cases in which parents made no comment	3%
Unfavorable or unpleasant side-effects	0

There were no complications in those cases in which treatment was started early, but in one child who received it late there developed asthamatic bronchitis in spite of the medication. This child, incidentally, was the only one who had a fever at the time it was accepted for the series.

The best results were obtained in those cases in which the therapy was started within twelve hours after the onset of symptoms. All failures occurred in children in whom symptoms and signs had been evident for twenty-four hours or longer before treatment was started. There was a history of some form of allergy in either the patient or its immediate family in 36 cases.

COMMENT

The results obtained from the use of pyranisamine maleate in the treatment of the common cold in a selected group of young children were so superior to those from all previous types of therapy in the experience of the parents that the subject became, and remained for weeks, the main topic of conversation wherever young mothers gathered on the station. The demand for the drug for treatment of other and older children became so insistent that the available supply was exhausted. In consequence, a syrup containing the only antihistamine agent then available on the Navy supply table was prepared and issued to satisfy the phenomenal demand.

CONCLUSIONS

Pyranisamine maleate is an excellent therapeutic agent for the treatment of the common cold in very young children. In the majority of cases it eliminates the coryzal symptoms and much of the cough of acute laryngitis. By reducing the nasal secretions, providing an airway through the nose and depressing the cough reflex, children are enabled to obtain a good night's sleep in most cases.

It reduces the incidence of complications when given within twelve hours after onset of symptoms.

The authors gratefully acknowledge the help of Mrs. Maude B. McCarty in the preparation of this paper.

U. S. NAVAL HOSPITAL
Phila., 45, Penna.

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THE IODINE PROBLEM

It is easy for individuals to look the other way if they do not recognize that the iodine problem is their own problem. Many people who take vitamin tablets and are careful about getting an adequate supply of vitamins neglect the iodized salt which will insure a health minimum of iodine for the normal person.

It has been seen how the thyroid secretion with its essential iodine affects growth, health, a normal skin, and an alert mentality. Doctors have found, in practicing obstetrics, that even where goiters were not involved, the giving of extra iodine decreased the number of miscarriages and increased the number of mothers who had an adequate milk supply. How much fatigue of the adolescent may be due to iodine-hunger is only a guess.

With today's emphasis on positive health, many medical authorities are actively endorsing the use of food iodine, as a simple, cheap, easy insurance against the possible handicaps of a subclinical iodine deficiency.—W. E. Sebrell, M. D., in Public Health Reports.

VALUE OF ELECTRIC SHOCK THERAPY

Ninety per cent of patients suffering with involutional melancholia treated with electric shock therapy show fairly prompt recovery, whereas before electric shock therapy only 40 per cent of these patients recovered. It is the opinion of most autohrities that, because of the great number of suicides associated with this illness, patients suffering with involutional melancholia should be cared for in an institution for mental disorders.—J. R. Caunders, M. D., in Southern Medicine and Surgery.

PITRESSIN AND MYOCARDIAL INFARCTION

By F. R. WHITTLESEY, M. D.
Morgantown, West Virginia

Within the past few years I have seen three cases in which, soon after the administration of pitressin, a major coronary infarction took place. Herewith are presented the summaries of these cases.

1. S. R., male, age 55, seen in May 1945 because of epigastric and lower sternal pain, and gas. Several attacks had occurred in two years' time. Relief always came if the gas "moved." Attacks were unrelated to effort, and had been ascribed to gallbladder disease. Examination of the heart, lungs and abdomen was entirely normal. Three days later gallbladder x-rays were made which disclosed no stones, but emptying was delayed. An injection of pitressin was given after the first films to clear gas, and was promptly followed by an attack of severe pain which required morphine for relief. The next day, after another attack of pain, an electrocardiogram was made which showed acute changes indicative of posterior infarction. The patient expired suddenly the following day. Though gallbladder disease undoubtedly existed, it is certain that this patient's major disturbance was in his coronary circulation.

2. M. T. P., male, age 55. This man, with clearly diagnosed angina pectoris of four years' standing, began to suffer more frequent and severe attacks in April 1946. Dissatisfied with advice, and suspecting other trouble, he saw another doctor and underwent gallbladder studies. Within a few minutes after the injection of pitressin to clear gas, he sustained an extensive posterior infarction, and remained completely disabled until his sudden death approximately three months later. The gallbladder plates were normal.

3. A. L., male, age 60, was seen at home in September 1948 because of upper abdominal pain, distention and gas. He experienced some relief after belching. Examination was negative except for slight hypertension. Two days later gallbladder x-rays were made. Pitressin was injected to clear gas, and within a few minutes an attack of severe epigastric and substernal pain occurred. An electrocardiogram made soon afterwards disclosed typcial evidence of an anterior infarction. After a long convalescence, with numerous recurring attacks of pain, he recovered and is now normally active but retired from work. His gallbladder plates were normal.

It seems to me that in these cases the injection of pitressin was a seriously damaging, if not a fatal procedure. Physicians[1] at the Mayo Clinic have reported four cases in which severe myocardial ischemia followed the use of pitressin in the course of a routine diagnostic procedure. Of their four cases three died, and it was felt that pitressin definitely should be blamed for the catastrophes. It is easy to confuse coronary disease with gallbladder disease, as any experienced physician knows.

When a doubt exists it would seem wise, first, to thoroughly examine the heart and, second, to use no pitressin when gallbladder x-rays seem necessary. The x-ray department[2] at the Mayo Clinic has worked out a thoroughly satisfactory routine for this study that makes pitressin no longer a necessary adjunct of cholecystography. Wherever else in medicine pitressin may be used, its hazard for those in the coronary age group should be remembered. It may be a dangerous, indeed a fatal drug, and should be used with caution, if at all.

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SELECTIVE PLACEMENT IN INSTITUTIONS

Medicine has neglected to use one of the most valuable tools in the management of the chronically ill and aged. All who have gone through an institution have noted the apathy and hopelessness of the residents. There are always a few, however, who are bright and active. They are the patients who have volunteered or have been assigned to tasks within their physical capacities.

The use of selective placement, whereby the physical capacities of the individual are matched against the physical demands of a job, can be used in an institution as well as in industry. Even though their disabilities may be severe, the great majority of the residents of public homes can do some task about the home. For some, it may be only simple housekeeping assistance; others have the ability and experience to direct various operations within the home.

Such jobs should carry regular compensation, even though it be small, for there is no greater satisfaction than that which comes through earning.—Howard Q. Rusk, M. D., in Virginia Medical Monthly.

INVOLUTIONAL PSYCHOSES

I have been impressed by the fact that very few people realize that a man can develop mental symptoms at the period of life corresponding to the menopausal period of woman. While subject to variation in the age of incidence, involutional melancholia occurs most frequently in women during the late forties and in men during the late fifties. This is the age generally known as the involutional age. Noyes says that this is the period of psychophysiologic stress and one when increasing threats to an insecure personality are prone to give rise to anxiety, depression and paranoid reactions.—J. R. Caunders, M. D., in Southern Medicine and Surgery.

ALLERGIC MANIFESTATIONS OF THE EYE*

By CHARLES T. ST. CLAIR, JR., M. D., F. A. C. S., and BEN W. BIRD, M. D.

The term "allergy" was first introduced to the medical world forty-six years ago by Von Pirquet and Schick. The term was used to denote the altered reaction which was produced by the first and second inoculations of cowpox virus.

Originally, Von Pirquet defined allergy as a "changed capacity to react to foreign substance." As stated more recently by Appelbaum,[1] "it is an abnormal response to certain extrinsic stimuli and it is an 'antigen-antibody' reaction." Actually, allergy is hypersensitivity of the tissue cells to allergens,—a class of substances which give rise to specific alteration in the reaction capacity of the tissue cells when administered to the animal body in a manner excluding their digestive disintegration. Technically, allergens are distinguished from true antigens only in that they do not appear to cause the production of true antibodies according to the usual laboratory technic, although the mechanism for producing reaction in human beings probably is the same. There is something in the blood which does react with the allergen. This substance, as yet unidentified and unisolated, reacts with the allergen. Every true allergen is believed to be a protein. The group includes not only all know proteins which are soluble in the animal body and chemically foreign to its basic tissue and plasma protein, but possibly some of the higher protein-split products and proteinlipoid combination.

After the initial reaction of immunity has passed off and the organism apparently has returned to normality, in some instances antibodies remain attached to the tissue cells and "sensitize" them. It is these antibodies which are responsible for the altered capacity to react to foreign substances and which initiate the allergic reaction when the "sensitized" cells subsequently are confronted with the same allergen. There is therefore substantial reason to believe that hypersensitivity in the allergic person depends on previous contact with the particular foreign substance. This is well demonstrated in one of the cases to be presented.

The concept of the mechanism involved presupposes the existence of antibodies within the cell proper as well as in the circulation. When the circulating antibodies are present in sufficient concentration to engage the antigen and thus protect the fixed cellular antibodies, the reaction ("immunity") takes place unnoticed. On the other hand, when the circulating antibodies are insufficient to offer the fixed cellular antibodies this protection, the antigen-antibody reaction takes place in the cells. In the latter case, the biochemical reaction liberates a histamine-like substance. The cells suffer a certain amount of damage or destruction. There is capillary dilatation from secondary stimulation of the vasomotor system accompanied by increased permeability of the vessel walls, exudation of serum containing toxins and local necrotizing inflammation or allergic inflammation.

Should the antigen-antibody reaction be extensive and severe, the liberation of histamine reaches a great height, and a general musculospasmodic reaction, or anaphylaxis, follows. The overproduction of histamine and the consequent dilatation of the arterioles disturbs the normal balance maintained by the vascular system and lowers the blood pressure. Immunity, allergy and anaphylaxis, then, are closely related to one another, differing only quantitatively. Progress in clinical allergy has been based on knowledge of the phenomena of experimental anaphylaxis.

Only those allergic conditions of the eye most commonly seen will be discussed in any detail in this paper, with illustrative cases presented. However, other conditions will be mentioned because they do occur.

The cells of practically every tissue of the body may acquire hypersensitivity, thus becoming so-called "shock tissues," and the various tissues of the eye are no exception in their susceptibility to allergic manifestations. The lids, conjunctiva and cornea are most frequently involved and will be discussed in more detail later. Cases of allergic scleritis and episcleritis have been reported in the literature, as have cases of uveitis.

Elschnig,[2] in 1910, introduced the theory that uveal pigment acts as an allergen in the causation of sympathetic ophthalmia.

THE LENS—Probably all ophthalmic surgeons are familiar with the severe intraocular reactions that occur at times when lens cortex is liberated in the anterior chamber. In practically all such cases the individual shows a positive skin reaction to lens protein in advance.

The occurrence of bilateral cataract in eyes of young adults that were previously normal has been reported innumerable times as being caused by some allergic manifestation.

THE OPTIC NERVE AND RETINA—Retrobulbar neuritis and optic atrophy often are due to sensitivity to alcohol, tobacco, quinine and arsenicals. Fortunately, the use of tryparsamide has now almost wholly been discontinued in

*Presented before the West Virginia Academy of Ophthalmology and Otolaryngology at the Annual Winter Meeting at Martinsburg, May 14, 1949.

favor of penicillin and fever therapy in the treatment of central nervous system syphilis.

THE RETINA—Retinal hemorrhages may occur due to allergic causes and may vary greatly in appearance and location. There is a tendency for these hemorrhages to recur. Most of these allergic manifestations are seen in young adults but they occur also in older individuals.

Retinal detachment in those patients having a definite history of personal or familial allergy may be considered allergic when there is no history of trauma, high myopia, tumor or other known factor.

Edema of the macula has been reported as due to allergy. An instance of dysfunction of the extraocular muscles with diplopia and vertigo due to the ingestion of certain foods has been reported. When the foods were withdrawn the attacks disappeared, but reappeared when the foods were taken again.

A case of glaucoma which we believe to be of allergic origin will be reported in this paper.

THE LIDS—There are several common allergic phenomena seen in the lids and surrounding skin. First of all, we may have angioneurotic edema with or without redness of the skin. This may be due to the ingestion of foods, drugs or inhalants, or to exposure to extremes of temperature.

Second, there is an erysipelas-like type with rather severe redness and itching which is more or less circumscribed in character. This may result from the use of mydriatics or miotics, local application of ointments to the eye, cosmetics, nail polish or other contacts.

Third, there is a scaly type of dermatitis of the lids which usually is accompanied by intense burning and itching.

Chronic blepharitis which proves resistant to all forms of local treatment usually will be found to have an allergic background.

CONJUNCTIVA—Allergic conjunctivitis is instigated by the same allergens which are responsible for allergic dermatitis of the lids, and is seen with or without involvement of the lids. We may roughly separate the condition into three classifications: acute, subacute and chronic. In the acute form only chemosis is observed. This comes on very suddenly and the chemosis may be moderate or quite severe, usually much to the alarm of the patient. It may be so extensive that closure of the lids is impossible. There usually is profuse lacrimation with burning sensations of the eye. Antistine drops every two hours, with cold packs, usually will result in prompt relief. When the patient is first seen a few drops of adrenalin are instilled, and reassurance given.

In the subacute type the onset is not so rapid and actually may come on rather slowly. This type is practically always associated with involvement of the lids which are eczematous, or red and swollen. There is redness of the bulbar conjunctiva, more pronounced in the middle portion of the eye which is not protected by the upper and lower lids. Usually there is slight chemosis present. There is some lacimation with itching and burning. Follicles may appear in the folds of the lower cul-de-sac. The discharge usually is of a sticky, mucoid nature. Smears from the conjunctiva may or may not show eosinophils, but probably more significant is the absence of infectious organisms when smears of scrapings are made.

The chronic type referred to here may best be called the "old red eyes," because the condition has existed over a long period of time, maybe even for years, without change in the situation. It is true that this type does have acute exacerbations, with follicle formation at the time, but they gradually disappear leaving slight congestion with itching. This condition usually is neglected due to the mildness of the symptoms, and is incorrectly assumed to be infectious. It is therefore usually further aggravated by the continued use of antiseptics. This chronic inflammation of the eyes often is mistaken by certain members of the laity as a symptom of alcoholism with much embarrassment to the usually innocent victim. Here again the absence of pathogenic organisms is significant. In the management of these cases all local treatment should be discontinued, and antistine, 0.50 per cent solution, should be substituted. One of the antihistaminic drugs for oral use may be tried. Most of these cases will be found to be of an occupational nature. Every effort should be made to discover the offending substance.

Vernal conjunctivitis is considered to be a chronic form due to allergy. However, it has been discussed so thoroughly in the literature that it will not be considered here. Apparently the best results in the treatment of this condition have been obtained through the use of beta ray irradiation.

THE CORNEA—Involvement of the cornea in allergic disorders usually is associated with some involvement of the lids. Various types of ulcers have been mentioned in the literature. In one form, described by Lemoine,[3] there were multiple pinpoint ulcers that nearly covered the entire surface of the cornea. In another form larger ulcers occur. These usually are situated at the

limbus; one case of this type is to be mentioned later. Lemoine[4] reported two cases of dendritic ulcers in one of which the patient was hypersensitive to chocolate, and in the other to pollens. He cited also an instance of herpes of the cornea due to hypersensitivity to chocolate and corn; withdrawal of these foods led to healing, while return of them to the diet led to a recurrence of the herpes.

It is a fairly well accepted theory that phlyctenular keratoconjunctivitis is an allergic reaction to tuberculoprotein. It has been noted often that in a patient who has had phlyctenular keratitis that has healed, the condition will recur when tuberculin is instilled into the conjunctival sac. There may be also a recurrence when some distant tuberculous focus is activated, and it is presumed that this is brought about by the transmission of the tuberculoprotein to the eyes through the tears or blood stream.

In syphilitic interstitial keratitis that is refractory to treatment, it is probable that Spirochaeta have been present in the cornea at the time of the original infection, whether congenital or acquired. This results in sensitization of the cornea, so that later on when the infection becomes manifest in another part of the body, toxins are released which then affect the already sensitized tissue of the cornea. A small percentage of cases of interstial keratitis which were due to tuberculoprotein, foods and airborne antigens have been reported.

CASE REPORTS

CASE 1.—The first case is that of a man age 59 who was first seen about a year ago. Penicillin ointment was prescribed for this patient as a prophylactic measure following an abrasion of the cornea. The ointment was instilled into the eye and a tight patch applied, to remain for twenty-four hours. After removal of the patch the patient used the ointment at regular intervals together with warm compresses for one day. On his return examination the eye was red and severely inflamed, the lids also being involved. Fortunately, since the abrasion had healed treatment was discontinued, and within a few days the reaction subsided. About one month ago, this patient complained of a headache which persisted for two or three days, and which was most unusual for him. He consulted a physician who gave him an injection of penicillin 300,000 units. The rationale of this treatment has not been clarified. About twelve hours later the patient was beset with severe itching and burning of the lids of both eyes together with photophobia and tears. There was marked swelling of the lids and severe conjunctivitis of both eyes. The disturbance was much greater in the right eye, the one that had been treated with penicillin locally when the injury had occurred. The cornea of this eye was involved with multiple ulcer formation around the lower half at the limbus. This patient had also a rash on the chest, arms, palms of the hands and legs. He was given pyribenzamine by mouth and antistine packs, also antistine drops for his eyes. He was away from work for over ten days.

CASE 2.—J. S. A., a white man, age 58, was first seen about one month ago, complaining of having had inflamed eyes for the past four or five years, worse at times, but more severe recently. The condition accompanied by itching, burning and tears. At other times he had only mild irritation. Various antiseptics had been used without relief.

The eye examination was entirely negative except for congestion of the conjunctiva, with a small amount of thick mucus in the cul-de-sac. Smears from the conjunctiva were negative both for pathogenic organisms and eosinophils. His vision was 20/25; his refractive error was found to be plus 0.50 cyl. ax. 90 in both eyes with plus 1.75 sph. add. bifocal. He was wearing approximately the same refraction. The patient lived some distance away and it was impossible for him to make regular visits to our office. We believed that he had an allergic condition, so we prescribed antistine drops and cold packs, with pyribenzaine. He was referred later to an allergist and skin tests showed very positive reaction to house dust and yellowdock, the latter a type of weed that was in season at that time of year. It was found that his side yard contained an abundance of the yellowdock weed.

The condition of his eyes has cleared up almost entirely and it is now our belief that after the causative agent is removed and injections of extracts of house dust are given, he will be improved of these symptoms.

This case is presented only because the patient has had rather energetic treatment in the past for infection of the eyes, and has had glasses three times for eyestrain.

CASE 3.—This case is that of a doctor in our locality who is extremely sensitive to all forms of local anesthetic. The sensitivity was first apparent on all of the fingers, later on both hands and wrists, and developing several months thereafter on the lids of the eyes.

Soon after the onset skin tests were made and positive reactions were found for practically all foods. However, since the history did not support these findings, further search was necessary.

Patch tests of certain drugs and two local anesthetics were placed on the patient's chest, with no reactions. Later, when the same patch tests were placed near the wrists, the local anesthetics were found positive.

It came to light that after a tonsil patient who had undergone local anesthesia had suddenly expectorated on the doctor's eyelids, severe swelling of his lids had developed within a short time. Now, when the aforementioned doctor removes tonsils under a local anesthetic, he always employs extreme measures to protect his eyes.

CASE 4.—A suspected case of allergic glaucoma. E. M., age 26, occupation student, was an ex-G. I. who had been home from service in the armed forces for only a few months and had enrolled as a college student. He complained of frequent headaches which affected the right eye and right temporal region. On examination the sinuses were grossly normal and the eyes were normal in appearance. The vision was 20/25 + 2 and 20/20. On cycloplegic examination December 2, 1946 (one drop 4% homatropine plus one drop 5% cocaine), he was found to have a small minus sphere and cylinder. He returned January 16, 1947 to say that he had had a recurrence of his headache for the past two days. The cornea of the right eye was steamy and insensitive. The pupil was dilated to 6 mm. and the tension elevated to 38 mm. That of the left eye was 22. Vision in the right eye was reduced to 20/70. There was no redness of the conjunctiva nor any ciliary congestion. The patient was patently under the influence of alcohol and eventually told us that since returning from the service he had been a periodic drinker. It was during these episodes that the eye pain and headache supervened, eventually resulting in such severe nausea and vomiting that perforce he recovered. Cold compresses, 1% eserine drops and abstention from alcohol resulted in a rapid drop of the tension to 16 mm. within twenty-four hours. He was again examined November 15 with the subjective findings being essentially the same. He stated that he had had two intercurrent attacks in the interim of eleven months. Since it was very difficult to obtain this patient's cooperation, an allergic study could not be made. We have assumed, from the history given by the patient and by members of his family, and from the subjective and objective symptoms, that this is an instance of allergic glaucoma.

TREATMENT.—We have been using for the local treatment of dermatitis and conjunctivitis just mentioned, antistine packs and drops. It is preferable to use cotton packs at two-hour intervals, also pyribenzamine or neohetramine which we have found to carry less objectionable side-effects than benadryl.

There are many other antihistaminic drugs that may be used such as histadyl, thenylene, neoantergen, a recent one, thephorin, and perhaps twelve or fourteen others. It becomes often a question as to which of these drugs is the best to be used. If we should believe all that is written and said concerning each individual product, then our preference might easily change with each reading. Actually all of these antihistaminic agents are alike in their actions, even though their chemistry may be different, but even in this the similarity is very close. In fact, two of them, histadyl and thenylene, are chemically and pharmacologically identical, but even these two are marketed under different names by different companies and claims of superiority are made for each one.

The average dosage of these drugs is 25 to 50 mg. given at four-hour or six-hour intervals. Patients report the side-effects as drowsiness, sleepiness, dizziness, stupor, numbness and, in some cases, tingling sensations. Due to the stupor, drowsiness or sleepiness that might occur, with the patient not being absolutely on the alert, it is best to advise these patients not to drive automobiles while taking the drug. It is believed that these reactions are due to the action of the drug itself rather than to the patient's susceptibility or idiosyncrasy, and that the action is dependent on the dosage of the drug employed. Therefore, in the more recent products the dosage recommended is less than formerly advocated. The foregoing, however, does not rule out the possibility that a very few patients might not be sensitive to the drug, even though it is an antihistaminic agent. In such cases, when the drug has been given, discontinued, and then administered again, and side-effects occur, sensitivity should be suspected.

The patient is not receiving adequate treatment in most of the eye conditions if his physician limits his management of the case to the use of one or more of the aforementioned drugs.

First and most important is a very carefully taken history. We should consider the patient's employment, his environment and his habits. Those factors that are suggested by the history should be tested by intradermal injections. The successful treatment of any allergic patient consists of the removal of the causative agent whenever this is possible.

Intradermal skin testing is a helpful aid in the sometimes discouraging "detective work" needed to discover the causative agent. We do not consider the presence or absence of a positive

skin test as being an absolutely diagnostic fact. Seasonal appearance of symptoms often is diagnostic. In general, if symptoms occur only in the winter months and are absent in summer, house dust is suspect. If symptoms occur in spring or fall, pollinosis usually is the answer. If symptoms are present the year round, foods, drugs, cosmetics and occupational contacts should be investigated.

Where food allergies are suspected, the elimination diets are of utmost importance. In many cases it is difficult to obtain the patient's cooperation. A "food diary" should be kept and thus sometimes valuable clues can be uncovered. In many cases, (as in that of the doctor herein reported) so many positive skin reactions are obtained that the picture is confused and an elimination diet is the only course practical. In other cases, very obviously food allergies, skin tests are entirely negative.

When the exciting factor cannot be removed, efforts to hyposensitize the patient should be made. When the causative agent is found to be cosmetics, soaps, or like contacts, the use of the so-called nonallergic products may be recommended.

In summary, we wish to note that in many patients treatment is most difficult. The best course that we can advocate at this time is as follows:

1. A carefully taken history.
2. Discovery and removal of the causative agent whenever possible.
3. Hyposensitization.
4. Antihistaminic drug therapy.
5. Local treatment with antistine packs and drops.
6. Cold compresses.
7. Mydriatics, miotics, adrenalin or ephedrine as indicated.

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SEX OFFENDERS

The belief is general that the sex offender is a mentally ill person. His problem exists in every community and many legislatures are currently aroused to its importance. Neither the ordinary insane asylum nor the ordinary jail is equipped to keep him. A special institution, either state or federal, would seem to be very much needed, for confinement and care of this particular type of offender, with facilities for study of him and for occupational therapy.—Southern Medical Journal.

CAREFUL SCREENING NEEDED

Medical editors who have been interpreting or editorially commenting on new drugs or treatments have been taught, or learn the hard way, that they may be saved the embarrassment of retracting some of the things which they may write under the influence of enthusiasm. If they do overstate any of them, they can usually tone down by remembering to close with one of their stock "outs," like: If this new drug and/or treatment proves to be satisfactory or successful or survives rigid clinical criteria and/or further laboratory study—another scientific victory will have been attained. This is precisely what intellectually honest authors expect them to say because they usually close their own articles with some such conservative sentence.

Regrettably, the printed publicity in newspapers and magazines would be considered lacking in "mass appeal" and "human interest" if the "punch" was diluted in such a way. Nevertheless, if the news of new medical discoveries was presented conservatively, the bitter disappointment of many patients might be less in case it did not fulfill clinical criteria. Furthermore, many would be prevented from mortgaging their homes to go to far away medical centers when their own physician had to tell them that the new drug or treatment was in an experimental stage and consequently was not available to him.—International Medical Digest.

THE DOCTOR AND THE COMMUNITY

The obligations of a doctor are not confined wholly to those in line with his profession. He is also a citizen. He belongs to the best educated, the best trained group, in any community. He has been trained to leadership, to think logically, to make quick decisions based on observation and logical deduction. Such a one owes it to his community to use those powers in community betterment in other realms besides that of medical care.

And, as the doctor grows older, having left behind the long years of training in school, in hospital and in early practice, having so served through the packed and crowded years of professional maturity as to win the confidence and esteem of his fellow citizens, he is better able to make his influence count in the things that strengthen and build the community.—W. L. Pressly, M. D., in J. South Carolina Med. Assn.

STATISTICAL STUDIES OF HEART DISEASE

Heart disease, the largest single category in the cardiovascular-renal diseases, is by far the most frequent of all causes of death. Hypertension and arteriosclerosis rank low as recorded primary causes of death in the United States, but intracranial lesions of vascular origin, usually preceded by hypertension or arteriosclerosis or both, are important causses of death. Nephritis in terms of numbers of deaths is roughly equivalent to intracranial lesions.

The three causes combined under the general title of cardiovascular-renal diseases, made up 48 per cent of all deaths in the United States in the 2 years, 1945 and 1946. These causes accounted for 10 per cent of all deaths at 15-24 years; 30 per cent at 35-44; 52 per cent at 55-64; and 66 per cent at 75-84 years of age. Thus in the older ages they constitute a very large proportion of the deaths from all causes.—Selwyn D. Collins, Ph.D., in Public Health Reports.

The President's Page

By the time this issue of The Journal is distributed in the mails it is probable that many members of the West Virginia State Medical Association will have paid their AMA dues along with local society and State Medical Association dues. Again, I urge each member to remit early for local, state, and AMA dues.

The proposal of the Council for the creation of a "grievance committee" is now being studied by the Committee on Revision of Constitution and By-Laws in consultation with a special committee from the Council. This matter should be reviewed by each component society, and any proposed amendments to the By-Laws will be referred by the Council in plenty of time for thorough study before our annual meeting at White Sulphur Springs, July 27-29. It should be borne in mind that the American Medical Association has recommended that grievance committees be set up by every State Medical Association. Favorable action has already been taken in eight states.

It was most gratifying to receive a copy of the resolution opposing any form of compulsory health insurance or system of political medicine which was adopted recently by the Northern Panhandle District Nurses' Association, representing 520 nurses. I have just been informed that three other District Nurses' Associations have taken similar action.

It is my sincere hope that all of the District Associations will in the immediate future adopt similar resolutions opposing socialized medicine. We are much too closely allied to have separate goals. Nurses would be equally affected with the doctors if this foreign "ism" should be forced upon the people of this country.

I take this opportunity to thank the members of standing and special committees who have so graciously accepted appointment, and whose pledge of full cooperation is deeply appreciated.

The program committee has just about completed arrangements for the annual meeting in July. Part of the program is being released in this issue of The Journal. I can assure you that the scientific program as outlined will be interesting to all of our members. It is my hope that every member of the State Medical Association will try to be present all three days of the meeting at The Greenbrier. Congratulations and thanks to the program committee for the good work that is being done.

C. E. Watkins

President.

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THE AMERICAN LEGION

The coming membership drive of the American Legion deserves the enthusiastic support of every physician veteran in West Virginia, and for that matter, in the entire United States. The veterans, tried in the crucible of fire, are the friends of the doctors, and especially the friends of freedom in medicine. They remember regimented medicine as they experienced it. The Legion nationally and locally is fighting our battles for professional freedom. Moreover, the West Virginia Legion is sponsoring the campaign of the Heart Association this year, the great drive against the greatest killer of mankind.

At least a thousand doctors in West Virginia have served with the armed forces. The aims and interests of the American Legion are so nearly the aims and interests of the entire populace that every eligible should join, and this is especially true of the doctors. We owe it to the Legion not only to become members but to become active and enthusiastic members. *Verbum sapienti sufficit.*

WE WONDER, TOO

The January issue of The Journal of the Arkansas Medical Society presents a one-sentence editorial: "We wonder if anyone ever asked a Navajo Indian, a ward of the Federal Government, what he thinks of the welfare state and security?"

Perhaps Mr. Ewing, or perchance the "Great White Father", might undertake to get the redskin's reaction. They might ask him also his ideas of compulsion as exercised beneficently (?) from Washington. We wonder what the Navajo would tell them? Poor Lo!

A GRIEVANCE COMMITTEE

Two component societies of the West Virginia State Medical Association have already taken action in the matter of the proposed creation by the House of Delegates of a state grievance committee. One of the societies went on record as favoring the proposal even before the Council acted, and the other took an opposite view by adopting a resolution after the Council meeting opposing such a committee.

Component societies are free to express their views in matters affecting the whole profession. This is as it should be. This is really medical democracy at work in a big way.

The Council, expressing unanimous approval of the creation of a grievance committee at the state level, properly and very wisely referred the matter to the Committee on Constitution and By-Laws, which, with a special committee from the Council, will study the need for and the advisability of taking this step. But, this is not all. If a favorable report is submitted to the Council, then any changes proposed in the by-laws will be referred to all component societies for consideration three months prior to the annual meeting at White Sulphur Springs, July 27-29, 1950.

There are most certainly arguments for as well as against this departure from the old order, and the two committees, as well as members of the component societies, will have every opportunity to study the proposal before it is submitted to the House of Delegates at the annual meeting.

NO PLACE FOR POLITICS

The Coal Valley News, of which Luther R. Jones is editor, believes that the question of socialized medicine is something that should be divorced from politics and not submitted as part of the program of any political party.

In a recent issue of this weekly newspaper it was stated editorially that if the administration is determined to push a program for compulsory health insurance, then the whole matter should be submitted as an amendment to the constitu-

tion, to be voted upon regularly by all the people of the country. The editorial continues:

"The News predicts that if socialized medicine comes, many of our best doctors will retire for the reason that restrictions imposed by law and bureaucratic regulation upon the conduct of their profession will be too cumbersome and obnoxious for them to continue in the practice of medicine through their advancing years.

"The freedoms heretofore enjoyed to practice medicine and choose one's own doctor are much too vital to be fouled in party politics. When party leaders can come along and — because they want to compel a country to swallow some new and revolutionary proposal — make of such a proposal a party issue, regardless of the personal views of their constituents, the threat to our instruments for maintaining freedom become real and the danger to our freedoms imminent.

"It follows of a certainty that all the Democrats of the land are not converted to an approval of the change because Mr. Truman says it is good for us. Nor will every Republican want to vote against it because Mr. Truman has compelled the country to take it as a party issue.

"If it must be decided, and a change so much at variance with our former practice and mode of life be acted upon — then, by all means, keep it out of politics, and submit it as an amendment to the federal constitution, to be voted upon by the people as they elect, without drawing political lines."

The News believes that the day of decision in the matter of our freedom draws near. "Every restriction permitted by the people," it says, "points the way and makes it easier to impose other and greater restrictions. The decision, however, rests ultimately with the people. If we let others decide for us, then the restrictions are yet of our making, and we will have earned them."

MEDICAL PRESENTATIONS

Some recent medical papers have shown a trend to stiltedness and especially to prolonged bibliographies, much to the discomfiture of editors and publication committees. Too many manuscripts approach monographs.

Alvarez, in a recent paper in the Proceedings of the Staff Meetings of the Mayo Clinic, calls attention to this tendency and makes a plea for brevity and succinctness in medical presentations generally.

An editorial writer in Archives of Physical Medicine (and we rather suspect it might be our old friend Richard Kovacs) discusses Alvarez' paper in a brief masterpiece playing this tendency. It is so much to the point and so well done that we quote a few paragraphs and commend them to the careful consideration of those who prepare papers for perusal by busy doctors on the firing line of medical practice:

"There is an acute need for shorter scientific papers, according to a recent article by the irrepressible Alvarez. He forcibly expresses many thoughts that must have arisen in the minds of many medical men as a reaction to the plethora in size and number of scientific papers.

"Alvarez says that today the ablest physicians, whose attention all writers want most to attract, are in the habit of quickly skimming through large numbers of articles, looking always for one thing, the new, significant, important and usable. Without any of the accompanying rehash, this grain of wheat could usually have been reported on a page or two.

"The worst thing a man can do is to write pages of introduction filled with tiresome statements the truth of which everyone knows, such as that the etiology of the disease under discussion is obscure and that some have said this and some that without getting anywhere. Many writers discourage their readers by inserting early in the paper a page or two on needless statistics or on the technic used. Many a discussion of the literature with a large bibliography should be left out. It would be better to say that a bibliography of several hundred titles is to be found in a recent article by so-and-so, or to write a separate review article.

"Big tables should usually be left out because so few readers stop to study them, and the cost of setting them is great. Oftentimes the data in several tables could, with great advantage, be shown in a graph or two, or could be summarized in a couple of sentences. Alvarez emphasizes that most papers are not injured but improved by shortening and points out that at the recent meeting of the American Medical Association he heard man after man present a good paper in ten minutes.

"Besides these aspects presented by Alvarez chiefly from the readers' standpoint, there are a few even more significant ones from the viewpoint of the listener. To get full benefit from a presentation, the audience wants clear diction, speaking directly to it, and the strict observation of the time allotted.

"Paraphrasing the immortal 'Mikado', some of the offenders that 'never will be missed' are: the speaker who gazes fixedly at his manuscript and mumbles off monotonously sentence after sentence; the speaker who after consuming the full time for the paper, proceeds to show an endless number of slides, and talks steadily to the screen with his back to the audience; the chairman, who starts his meeting late and 'like a good fellow' contentedly allows early speakers to transgress their time considerably with the result that the meeting is ruined for the later speakers and the audience becomes confused and irritated.

"Perhaps the time will come when no one will be allowed to address or preside over a meeting without a certificate of competency."

NATIONAL PLANNING

Information is leaking out of political councils to the effect that the Administration forces, which are advocating socialized medicine, plan to make the 1950 political campaign a proving ground. Five states are to be selected where the candidates are outspoken advocates of the compulsory national health program of Truman, Ewing, Murray, Pepper, Falk, et al. The whole force of bureaucratic and other machinery will be concentrated in these five states. If the socialized medicine candidates win, the drive will be on throughout the nation.

Until the American people can be thoroughly taught and convinced that we do not want state socialism or any part of it (and socialized medicine is a part of it) this threat will be ever present and we in medicine must be prepared to continue America's fight for personal independence.—J. Michigan State Med. Soc.

GENERAL NEWS

MCV TO PRESENT OPENING PROGRAM AT ANNUAL MEETING, JULY 27-29

The program for the 83rd annual meeting of the West Virginia State Medical Association is nearing completion, and the schedule for the entire three days will be released within the next few weeks.

For the first time in the history of the State Medical Association, a medical school has been asked to supply speakers for an entire scientific session. The invitation extended by the program committee to the Medical College of Virginia has been accepted, and the group from that school will present the opening program on Wednesday morning, July 27.

This program will be in the nature of a seminar or symposium on "Gastrointestinal Diseases," and will include papers on treatment and control and possibly a discussion of the medical, surgical, pathological, and radiologic aspects of such diseases. It is probable that the program for that morning will include four speakers, and a panel discussion will follow the presentation of the last paper.

Under an arrangement with West Virginia University, the Medical College of Virginia enrolls annually twenty graduates of West Virginia University School of Medicine and such graduates receive their third and fourth year in medicine at Richmond.

The Friday program has not been completed, but it is now known that Dr. George M. Curtis, Professor of Experimental Surgery at Ohio State University School of Medicine, in Columbus, will open the program. There will be a panel discussion following the Friday morning session.

Dr. Frank H. Lahey, of Boston, will appear on the program Saturday morning, July 29. This will mark his first appearance at an annual meeting in West Virginia since 1941, when he appeared as a guest speaker at White Sulphur Springs.

At the same session, Dr. Philip Thorek, of The Mayo Clinic, will appear as a guest speaker. Two other papers will be presented that same morning. A question and answer period will follow the address of the fourth speaker on the program.

The presidential address of Dr. Charles E. Watkins, of Oak Hill, is scheduled for Thursday evening, July 27. Mrs. Dana T. Moore, of Parkersburg, president of the State Auxiliary, will also appear on this program.

Dr. Elmer L. Henderson, of Louisville, Kentucky, President of the American Medical Association, will be the guest speaker at an open meeting scheduled for Friday evening, July 28. This will be the first time for several years that a president of the parent organization has attended an annual meeting of the State Medical Association.

The committee which is making arrangements for the 1950 convention is composed of Dr. J. P. McMullen, of Wellsburg, chairman, and Drs. R. M. Flood, Cove Station, Weirton, and E. J. Liere, of Morgantown, Dean of West Virginia University School of Medicine.

FOUR-YEAR SCHOOL STUDY UNDER WAY

Information has been received at the headquarters offices of the West Virginia State Medical Association that Dr. Wilburt C. Davidson, dean of Duke University School of Medicine, and Dr. Herman G. Weiskotten, dean of Syracuse University College of Medicine, are gathering statistical information concerning the advisability of the creation of a four-year school of medicine and dentistry in West Virginia, and that they both expect to visit in the state for at least a week early in March.

Dean Weiskotten and Dean Davidson were named by the legislative interim committee under authority of a resolution adopted at the regular session of the legislature in 1949.

Independent reports are to be submitted to the iterim committee, and Senate President W. Broughton Johnston, co-chairman of the committee with House Speaker William E. Flannery, has stated that a meeting will be held promptly when reports are submitted. It will be decided at that time whether to make the reports public or hold the same until the legislature convenes in January, 1951.

The report that will be considered by the interim committee will no doubt be referred for study to the advisory committee on four-year school appointed by Governor Okey L. Patteson in July, 1949.

1595 DOCTORS IN ACTIVE PRACTICE

A total of 1,649 West Virginia doctors have renewed their license to practice medicine in West Virginia under the reregistration law which became effective July 1, 1949. In addition, 198 doctors residing outside of West Virginia have renewed their license for the biennium.

The registration, which has been completed by the State Department of Health, also includes the names of 54 West Virginia doctors who have retired from practice. This would indicate that there are 1,595 doctors in active practice in the state at the present time.

A report submitted to the Council on January 8 disclosed the fact that the membership of the West Virginia State Medical Association has reached an all-time high of 1,425. Of this number, 125 doctors are honorary members.

S. E. ALLERGY ASSOCIATION

The 5th annual meeting of the Southeastern Allergy Association will be held February 11-12 at the Columbia Hotel, in Columbia, South Carolina.

TB AND HEALTH ASSOCIATION TO MEET

The annual meeting of the West Virginia Tuberculosis and Health Association will be held September 20-21, 1950, at the West Virginian Hotel, in Bluefield.

COUNCIL PROPOSES CREATION OF STATE "GRIEVANCE COMMITTEE"

At a meeting of the Council of the West Virginia State Medical Association, held January 8, 1950, at Charleston, with all members present, a movement was initiated for the creation by the Association of a "Grievance committee" which would have full power to investigate matters of an ethical nature referred to it for study from any part of the state. Such matters would no doubt include complaints regarding fees and professional services.

The Council unanimously adopted a motion to request the committee on Revision of Constitution and By-Laws to prepare the necessary amendments for submission to the House of Delegates at the annual meeting at White Sulphur Springs, July 27-29, 1950. The chairman was authorized to appoint a special committee from the Council to assist in a study of the proposal, and subsequently Dr. Thomas G. Reed named Drs. E. L. Gage, of Bluefield, George F. Evans, of Clarksburg, and James S. Klumpp, of Huntington, as members of the committee. Doctor Gage will serve as chairman of the Council group.

The proposal for the creation of the committee, modeled after similar committees set up in eight other states, was discussed by several members of the Council. The AMA House of Delegates has recommended that a committee be named by each state medical association or society.

The Council was told that committees have already been named by state medical groups in Colorado, Nebraska, Oklahoma, New Mexico, Utah, Virginia, Indiana and Kentucky.

It was further reported that the by-laws now empower councillors to serve as censors in their respective districts, the Council itself constituting a board of censors for the State Medical Association to which appeal may be made by members from the decision of any councillor.

It was brought out in debate that, while the desirability and advisability of the creation of a grievance committee cannot be questioned, every effort should be made to have controversies involving ethics, conduct of members, and services rendered heard and settled at the local level.

The committee on Revision of Constitution and By-Laws, in consultation with the special committee from the Council, was asked to make a study of the matter immediately and report to the Council, with recommendations, more than 120 days prior to the 83rd annual meeting at White Sulphur Springs.

AMA Dues for 1950

The Council also went on record as approving the levying of AMA dues in the amount of $25.00 for each member in 1950.

It was reported that the AMA feels that all honorary members should be required to pay dues unless such payment actually constitutes a financial hardship. No state dues are collected from honorary members of the West Virginia State Medical Association.

It was ordered that honorary members of the State Medical Association who feel that the payment of AMA dues would constitute a financial hardship be requested to so report to their local secretary or treasurer. If such official recommends that dues be waived on the ground that collection would constitute a financial hardship, the state headquarters office is to notify the AMA to that effect and ask that the doctor be continued as a member in good standing.

The executive secretary was directed to outline to the secretaries and treasurers of component societies the procedure to be followed in the collection of AMA dues, and it was understood that Dr. C. E. Watkins, the President, is to mail a letter on the subject to each member.

Standard Procedure for Autopsies

A letter was read from Mr. H. Eugene Merrill, executive secretary of the West Virginia Funeral Directors Association, requesting that some action be taken by the State Medical Association looking toward a standardization of procedures for autopsies.

Several memebrs of the Council discussed the request, and the chairman was unanimously directed to appoint one member of the Council to join with two representatives of the Funeral Directors Association and two from the Association of Pathologists of West Virginia for the purpose of considering the advisability of trying to obtain the passage of such legislation on the subject as may be thought necessary.

The executive secretary was directed to send a copy of Mr. Merrill's letter to the secretary of each component society for the information of the members.

Subsequently, Dr. Thomas G. Reed named Dr. Russel Kessel, of Charleston, as the Council member of the proposed committee.

Insurance Examination Fees

The executive secretary submitted the following report concerning the effort that has been made to obtain an increase in fees for medical examinations from life insurance companies and casualty, health and indemnity insurance companies doing business in West Virginia:

At a meeting of the Council of the West Virginia State Medical Association held October 3, 1949, at Parkersburg, the executive secretary was directed to contact the life insurance companies and the casualty, health and indemnity insurance companies doing business in West Virginia with a view to obtaining an increase in fees for medical examinations.

A form letter was prepared and mailed September 1, 1949, to each of the 100 life insurance companies and the 108 casualty, health and indemnity insurance companies licensed to do business in this state. A copy of this form letter has heretofore been furnished to each member of the Council.

Indemnity Insurance Companies

Casualty, health and indemnity insurance companies do not require medical examinations except in special

cases. When the need for such examination arises then the fee is agreed upon by the examining doctor and the insurance company. This policy holds for practically all of the casualty, health and indemnity insurance companies which have replied to our form letter.

Life Insurance Companies

From the replies received from life insurance companies, it is found that the volume of business of several such companies doing busines in West Virginia is not sufficient to require fixed fees for examinations. When examinations are required, then the fee is agreed to in advance by the doctor and the life insurance company.

The overwhelming majority of life insurance companies have heretofore maintained a fixed fee of $5.00 for medical examinations. A few have been paying fees slightly under that amount. No increases in prevailing fees in excess of 50 per cent have been reported by any life insurance company.

Fees Increased

As of this date (January 1, 1950), replies have been received from 33 life insurance companies, and from 21 casualty, health and indemnity insurance companies.

The following eight life insurance companies have reported that during the past year fees for medical examinations have been increased from $5.00 to $7.50:

Connecticut General Life Insurance Company
Connecticut Mutual Life Insurance Company
Equitable Life Assurance Society
Fidelity Mutual Life Insurance Company
New York Life Insurance Company
Travelers Insurance Company
Pacific Mutual Life Insurance Company
Bankers Life Insurance Company

This represents a 50 per cent increase in fees over the schedules of these insurance companies previously in effect.

The following four life insurance companies report that during the past year substantial increases have been made in their fee schedules for certain types of medical examinations:

Business Assurance Company
Commonwealth Life Insurance Company
Guardian Life Insurance Company of America
Massachusetts Mutual Life Insurance Company

Study Being Made

It is interesting to note that six life insurance companies report that the matter of an increase in fees for medical examinations is now being given special study.. These Companies are

Berkshire Life Insurance Company
Federal Life and Casualty Company
Home Life Insurance Company
Paul Revere Life Insurance Company
United Benefit Life Insurance Company

Another company, the Acacia Mutual Life Insurance Company, reports that the fee for a medical examination remains at $5.00, but that special fees are allowed where additional information is required.

No Increase Contemplated

Several life insurance companies report that no increase in fees is contemplated at the present time. Various reasons are assigned for this stand, the principal one being that it is thought inadvisable to increase fees for medical examinations unless premium rates are increased, and such increase seems improbable at any time in the near future.

Some of the companies feel that a fee of $5.00 is adequate for the services rendered, and others report that there is very little complaint from doctors concerning the amount of the fee paid for this type of serivce.

No increase in fees for life insurance examinations is being considered at the present time by the following 18 life insurance companies which have replied to our form letter:

American United Life Insurance Company
Equitable Life Insurance Company of Iowa
Farmers and Traders Life Insurance Company
General American Life Insurance Company
Kentucky Central Life and Accident Insurance Company
Liberty Life Insurance Company
Life Insurance Company of Virginia
Metropolitan Life Insurance Company
Minnesota Mutual Life Insurance Company
Mutual Benefit Life Insurance Company
New England Mutual Life Insurance Company
Northwestern Mutual Life Insurance Company
Pan-American Life Insurance Company
Penn Mutual Life Insurance Company
Pilot Life Insurance Company
Provident Mutual Life Insurance Company
Shenadoah Life Insurance Company, Inc.

Membership at All-Time High

The executive secretary reported that there were 1,425 members of the State Medical Association as of January 1, 1950, an all-time high. Of this number 125 are honorary members.

Official Spokesman

Several members of the Council discussed the advisability of the appointment of an official spokesman for the West Virginia State Medical Association, and it was generally agreed that favorable action should be taken in the matter. By the unanimous vote of the Council, Dr. Frank J. Holroyd, of Princeton, chairman of the state PR committee, was named official spokesman for the Association.

Nurses' Liaison Committee

Dr. M. H. Porterfield submitted a progress report for the Nurses' Liaison committee. It was reported that a meeting with representatives of the West Virginia State Nurses Association had been held in Charleston. January 7, with all three members of the committee being present. The other members of the committee are Drs. L. Rush Lambert, of Fairmont, and W. F. Richmond, of Beckley, who is chairman.

Pre-Convention Meeting

It was ordered that the Council meet in pre-convention session at The Greenbrier hotel, White Sulphur Springs, Wednesday evening, July 26, 1950.

UMW Fee Schedule

A letter concerning the advisability of the Council being prepared to consider any fee schedule which might in the future be submitted by the UMW Welfare and Retirement Fund was discussed by several members and ordered referred to the special UMW advisory committee for consideration.

Honorary Members Elected

The following doctors were named honorary lifetime members of the West Virginia State Medical Association: C. W. Vick, Bluefield; A. A. Shawkey, Charleston; C. N. Watts, Charleston; J. C. Collins, Fairmont; O. E. Reynolds, Huntington; H. H. Farley, Logan; and D. D. Hatfield, Yukon.

AMA Associate Fellowship

Dr. S. G. Moore, formerly of Elkins, now residing at Stephens City, Virginia, was nominated for associate fellowship in the AMA.

IN PRACTICE OVER 50 YEARS

Dr. B. A. Smith, of Spencer, who has been active in practice for over 50 years, is taking a most deserved vacation. He is spending the winter with his daughter in Huntington, but will return to active practice in Spencer early in the spring.

Doctor Smith is 82 years of age, and has been a member of Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association since 1930.

CONGRESS ON INDUSTRIAL HEALTH

The 10th annual Congress on Industrial Health will be held February 20-21 at the Roosevelt Hotel in New York City. The AMA Council on Industrial Health and the Medical Society of the State of New York will be co-sponsors of the meeting.

DR. W. E. KING CERTIFIED BY ABS

Dr. W. E. King, of Morgantown, has been certified as a diplomate of the American Board of Surgery. Certification followed the examination held in Baltimore late in the year.

WEIRTON MALE CHORUS ENTERTAINS AT ANNUAL BANQUET JULY 29

The principal entertainment feature of the banquet on Saturday evening, July 29, at the 83rd annual meeting of the West Virginia State Medical Association, at The Greenbrier, White Sulphur Springs, July 27-29, will be the appearance of the Weirton Steel Male Chorus, composed of over thirty members. This group, which will appear through the courtesy of the Weirton Steel Company, will probably present a program lasting from 45 minutes to an hour.

Arrangements for the appearance of the chorus, which enjoys a nationwide reputation, was made by the program committee with Thomas E. Millsop, of Weirton, president of Weirton Steel Company, and R. M. Corll, manager of Industrial Relations.

The chorus, which is under the direction of T. Herbert Davis, with Gerald Ferguson as accompanist, first gained prominence by being awarded first prize over 32 competing choruses in the Pittsburgh Sun-Telegraph Music Jubilee held at Forbes Field in 1937.

Upon invitation of the Governor of Ohio, the chorus represented West Virginia at the Cleveland Exposition on "West Virginia Day." From then on, there has been a succession of successful appearances made in many parts of the United States.

The chorus has made two appearances at the Waldorf-Astoria Hotel in New York City, and has also appeared on the Diamond Horseshoe program and Fred Waring's Chesterfield Hour.

During the past few years the chorus, which is composed of employees of all departments of the Weirton Steel Company, has presented concerts in Cincinnati, Chicago, Indianapolis, Cleveland, Columbus, Philadelphia, Atlantic City, and many other cities in the Ohio Valley. The chorus has been invited to appear three times in Atlantic City.

Weirton Male Chorus

BROTHERS NAMED TO HEAD SEPARATE COMPONENT SOCIETIES DURING 1950

For the first time in the history of the West Virginia State Medical Association, so far as the records disclose, two members who are brothers have been elected president of separate component societies to serve during the same period of time.

Dr. John F. McCuskey, of Clarksburg, became president of the Harrison County Medical Society January 1, and on the same date his brother, Dr. Paul L. McCuskey, assumed office as president of the Parkersburg Academy of Medicine. Each will serve during 1950.

Both served in the 106th Station Hospital overseas during World War II, and both were given honorable discharges from the service in January, 1946. They are sons of Dr. Roy McCuskey, one-time president of West Virginia Wesleyan College. He is a retired Methodist minister now residing in Parkersburg.

Each doctor is a urologist, and both obtained part of their academic education at Wesleyan College. Each received his M. D. degree at Northwestern University Medical School. Dr. John F. McCuskey had his first two years of medicine at West Virginia University School of Medicine.

Dr. John F. McCuskey has served as secretary of the Harrison County Medical Society for the past two years, and Dr. Paul L. McCuskey served as local PR chairman during 1949. Both have been active in the public relations work of the State Medical Association.

THE HEART CAMPAIGN IN WEST VIRGINIA

The West Virginia Heart Association reaffiliated with the American Heart Association in Dcember, 1948, following several years of operation as an independent group. In 1949, the national organization conducted the first Heart Campaign under the expanded program. Harold Stassen served as national campaign chairman.

The 1950 campaign for funds will be conducted during the entire month of February. The week of St. Valentine's day will be observed as "Heart Week," with Andrew W. Robertson serving as national campaign charman, and Winthrop W. Aldrich as treasurer. The goal is $20,000,000.

The goal in West Virginia this year has been tentative set at $50,000, and the campaign is being conducted under the sponsorship of the American Legion, Department of West Virginia. E. D. Hardman, of Charleston, has been appointed by the State Commander, Walter Long, as state campaign chairman, with headquarters at 30½ Capitol Street, Charleston. Mrs. Carolyn Rainbolt is serving as campaign executive secretary. District commanders of the American Legion have been appointed as district chairmen of the campaign.

It is most appropriate that the American Legion sponsor the national heart campaign in 1950, for it has a long record of cooperation with the American Heart Association and its affiliates. In 1946, this organization and its Auxiliary contributed $50,000 to the American Heart Association to serve as the nucleus for a nationwide fund raising expanded program.

"CANCER BULLETIN" DUE SOON

Copies of the first issue of "Cancer Bulletin," a bi-monthly educational service offered by the division of cancer control of the State Department of Health, will be mailed within the next few weeks to all doctors in West Virginia. It will be the aim of the Bulletin to furnish the latest cancer information to all of the doctors practicing in this state.

The Bulletin originated in Texas in 1948 as the "Texas Cancer Bulletin." The favorable reception given this publication resulted in a grant being made by the National Cancer Institute to assist states in making it available to all practicing physicians.

Providing an entirely different approach to medical writings, the Bulletin is designed to attract the attention of the busy private practitioner, providing him with information of the most important advances in the field of cancer treatment and control. A summary of the material on cancer carried in a multitude of Journals will be provided in brief, easy-to-read articles, colorfully illustrated by classic abstract, or anatomic art. Numerous references will accompany the text.

Since the first issue published in January, 1948, circulation has increased from 8,000 to 75,000. The Bulletin is now being distributed to doctors in twenty-five states and territories. Distribution is made possible through the cooperation of the Texas Cancer Coordinating Council, the National Cancer Institute of the USPHS, and various state and local divisions of the American Cancer Society.

RURAL HEALTH CONFERENCE

The 5th Annual Rural Health Conference, sponsored by the American Medical Association, will be held in Kansas City, Missouri, February 2-4, 1950. This will mark the first time that the conference has been held outside of Chicago.

Five topics will be discussed at the meeting: (1) Rural medical facilities at the local level; (2) Relation of agricultural extension service to rural health problems; (3) Community responsibility for health service in rural areas; (4) Methods for prepayment for health services in rural areas; and, (5) The responsibility of the medical schools in the rural health program.

Farm organization leaders, agricultural educators, farm editors, and representatives of other rural groups have been invited to attend the meeting.

DR. NELSON ELECTED TO CITY COUNCIL

Dr. George O. Nelson, of Nitro, has been elected a member of the Nitro city council to succeed H. R. Spence, who has moved to Camden, New Jersey.

KIWANIS OPPOSES STATE MEDICINE

At the annual convention of the West Virginia District, Kiwanis International, held October 4, at Morgantown, the following resolution was adopted:

"WHEREAS—The United States has the highest standards of health, of medical care and of scientific medical facilities of any country in the world, as a result of our system of Free Enterprise; and

"WHEREAS—Compulsory Health Insurance, wherever tried has caused a decline in national health and deterioration of medical standards and facilities, and

"WHEREAS—Wherever the government has assumed control of medical services, the result has been tremendous multiplication of costs over original estimates, extreme tax burdens and national deficits and gradual extension of socialization into other activities of national life, now, therefore,

"BE IT RESOLVED—That the Kiwanis District of West Virginia does hereby go on record against any form of compulsory health insurance or any system of political medicine designed for national bureaucratic control: also,

"BE IT FURTHER RESOLVED—That a copy of this resolution be forwarded to the President of the United States, to each Senator and Representative from the State of West Virginia, and that said Senators and Representatives be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation."

CENTRALIZED BOOKKEEPING SERVICE

Harry Winston, manager of the Physicians and Dentists Business Bureau in Charleston, has made available to the doctors of the Kanawha area a compact centralized bookkeeping service. Only one record is required to be kept by the doctor, and this is a simple daily entry form. Thereafter the doctor's responsibility ends, and the Bureau handles everything.

Doctors using this new bookkeeping service are assured that a change in office personnel will not disrupt the business side of professional practice. Assistants are afforded additional time for other essential duties.

Interested doctors may communicate with Mr. Winston for more detailed information concerning this new service.

DR. GWINN RETURNS TO PINECREST

Dr. G. E. Gwinn, who has been on the medical staff at Catawba Sanatarium, Virginia, for the past year, has accepted appointment as a member of the medical staff at Pinecrest Sanatarium, Beckley.

Dr. Gwinn was superintendent at Pinecrest for several years, resigning in November, 1947. He served for a while with the Veterans Administration regional office at Clarksburg, and a year ago accepted a transfer to Catawba Sanatorium.

MONTGOMERY REELECTS DOCTOR SKAGGS

At the biennial municipal election held at Montgomery, January 5, Dr. H. C. Skaggs, of that city, was reelected Mayor for his fourth consecutive term.

BY-LAWS COMMITTEE MEETING

Dr. Sobisca S. Hall, of Clarksburg, chairman of the Committee on Revision of Constitution and By-Laws, is having a meeting of his committee as this issue of The Journal is on the press (January 26).

The special group from the Council is sitting with the committee which is considering the advisability of the creation of a state "grievance committee," a proposal which has received the unanimous approval of the Council.

It is expected that a report will be submitted to the Council for consideration at the next meeting, which will probably be held late in March or early in April.

AMA MEMBERSHIP CARDS

A membership card and certificate will be mailed by the American Medical Association to all members who pay AMA dues for 1950. Dues are to be transmitted by local society secretaries and treasurers to the West Virginia State Medical Association, which will make frequent remittances to Chicago, accompanied by lists of paying members. Receipt of dues at the offices of the State Medical Association at Charleston will be acknowledged by a letter addressed to the secretary or treasurer in which the names of the paying members will be listed.

DR. KNAPP NAMED TO SPENCER POST

Dr. C. E. Hammer, superintendent of Spencer State Hospital, Spencer, has tendered his resignation effective January 1, 1950. Doctor Hammer will return to Columbus, Ohio, where he has accepted a position on the medical staff of the Columbus State Hospital.

Doctor Hammer has served as superintendent at the Spencer institution since February 1, 1948. Previously, he had served for two years (1946-47) there, but resigned to go to Columbus, returning to Spencer to succeed Dr. Edward Hawke as superintendent.

Dr. Thomas S. Knapp, assistant superintendent, has been appointed acting superintendent, effective January 1, 1950.

NEW HEAD FOR DENTAL HEALTH BUREAU

Dr. N. H. Baker, of Charleston, has been appointed by Dr. N. H. Dyer, State Director of Health, as acting Director of the Bureau of Dental Health. He succeeds Dr. George W. Wyatt, who resigned effective January 15.

Doctor Baker has practiced his profession of dentistry in Charleston for 38 years, and has served as director of dental health in Kanawha County for the past 17 years. He was the dental member of the public health council for 10 years prior to July, 1949, when the functions of the council were taken over by the new medical licensing board.

AMERICAN BOARD OF OPHTHALMOLOGY

Applications are now being accepted by the American Board of Ophthalmology for the 1951 written test. They will be considered in order of receipt until the quota is filled.

Practical examinations for acceptable candidates will be held during the next few months as follows: Boston, May 22-26; Chicago, October 2-6; and West Coast, January 1951.

Full information concerning examinations may be obtained by writing to Dr. Edwin B. Dunphy, Secretary, 56 Ivie Road, Cape Cottage, Maine.

RELOCATIONS

Dr. Lyle A. Moser, of Charleston, has moved to Eleanor, where he will continue in general practice. Doctor Moser was formerly located at Minden, and moved to Charleston in 1948.

* * * *

Dr. James M. Bonnar, who has been active in the practice of radiology in Fairmont since 1941, has retired from practice and moved to Middleboro, Massachusettes.

* * * *

Dr. Esten J. Hendricks, of Lillybrook, has moved to Princewick, where he will continue in general practice.

SECRETARIES' AND PR CONFERENCES

The annual Secretaries' Conference sponsored by the West Virginia State Medical Association is being held at Charleston, January 29, 1950. Besides the secretaries, all of the presidents and treasurers of the 29 component societies have been invited to attend.

At the conclusion of the conference, these officials will join with the chairmen of local public relations committees in a conference at which the state public relations program for 1950 will be unfolded.

A joint luncheon will be served at noon following the secretaries' conference.

AMA HONORS DOCTOR DYER

A certificate of appreciation for "constructive and friendly cooperation" has been awarded by the American Medical Association to Dr. N. H. Dyer, state director of health, for the part he played in helping to make the AMA Health Education Program, "Your Health Today", a success. The program was broadcast in 1949 over the NBC network.

FOR RENT: Three-room office with reserved parking space, available on Quarrier Street, Charleston, on July 1, 1950. Present occupant, general practitioner, leaving on account of health. Two blocks from all hospitals. Reasonable rent, long lease.—Box A, West Virginia Medical Journal, Box 1031, Charleston 24, W. Va.

OBITUARIES

OKEY JOHNSON CASTO, M. D.

Dr. Okey Johnson Casto, 69, of Parkersburg, died in a hospital in that city, November 29, 1949.

Doctor Casto was born at Ripley and received his early education in the public schools of Jackson county. He received his M. D. Degree from the Maryland Medical College in 1902, and was licensed to practice in West Virginia that same year, locating at Elizabeth. He moved to Parkersburg in 1916, where he continued in active practice until his death.

Doctor Casto was a member of the Parkersburg Academy of Medicine, the West Virginia State Medical Association, and the American Medical Association.

Besides his widow, he is survived by a son, Dr. Charles F. Casto, of Parkersburg, and four sisters, Mrs. Nellie Ball, of Charleston, Mrs. Bessie Chenoweth, of Florida, and Mrs. Clarence Rathbone and Mrs. Vertie Staats, both of Parkersburg.

* * * *

JOHN TREVY GOFF, M. D.

Dr. John Trevy Goff, 56, of Smithville, died suddenly January 6, 1950. He had retired from active practice several years ago on account of ill health.

Doctor Goff graduated from the University of Maryland School of Medicine in 1924, and was licensed to practice in West Virginia that same year. He had practiced his profession at Parkersburg, Burnt House and Smithville. He was a former member of the Parkersburg Academy of Medicine, the West Virginia State Medical Association, and the American Medical Association.

* * * *

G. B. IRVINE, M. D.

Dr. G. B. Irvine, 70, of Williamson, died January 4, 1950, at a hospital in Roanoke, Virginia. He had been ill for several months.

Doctor Irvine was born in Bedford County, Virginia, and received his academic education at New London Academy and Hampden Sidney College. He received his M. D. degree at the University College of Medicine, Richmond, in 1901. He was licensed to practice medicine in West Virginia in 1902 and located at Coopers. He had engaged in general practice at Williamson for the past thirty-five years.

He was a member of the Mingo County Medical Society, the West Virginia State Medical Association, and the American Medical Association. He had served as president and secretary of his local Society, and was a former city health officer at Williamson.

Utopia: The conditions that will prevail when Americans enjoy 1949 wages, 1926 dividends, 1932 prices and 1910 taxes.—The Comma.

COUNTY SOCIETIES

Dr. Charles L. Leonard, of Elkins, was elected president of the Barbour-Randolph-Tucker Medical Society at the regular monthly meeting held December 15 at the Main Street restaurant in Parsons. Other officers were elected as follows: First vice president, Dr. M. S. Lilienfeld, Parsons; second vice president, Dr. A. Kyle Bush; Philippi; and treasurer, Dr. W. G. Harper, Elkins. Dr. Donald R. Roberts, of Elkins, was reelected secretary.

Drs. Guy Michael, Parsons, and Hu C. Myers, Philippi, were elected delegates to the House of Delegates, and Drs. Charles L. Leonard and John Lennox, alternates.

The following doctors were elected to membership in the society: S. I. Adelman, Vernon Duckwall, and Max Harris, all of Elkins.—Donald R. Roberts, M.D., Secretary.

* * * *

CABELL

Dr. Ralph M. Caulk, of Washington, D. C., was the guest speaker at the regular monthly meeting of the Cabell County Medical Society held December 8 at the Hotel Frederick, in Huntington. His subject was, "The Diagnosis of Diseases of the Pharynx and Larynx." The paper was illustrated by lantern slides, and the discussion opened by Dr. W. B. Martin.

Dr. Otis E. Reynolds, of Huntington, was unanimously elected a honorary member of the Cabell County Medical Society. Dr. R. R. Dennison, of Stone, Kentucky, was elected a member by transfer from the Mingo Society.

The president announced the appointment of Dr. Albert C. Esposito as chairman of a new Sight Saving Committee. The other members are Drs. Charles M. Polan, Dorsey P. Ketchum and M. W. McGehee.—Thomas B. Baer, M.D., Secretary.

* * * *

EASTERN PANHANDLE

Dr. Kenneth Nelson, Medical Director of the Washington (D.C.) Regional Blood Center, was the guest speaker at the annual meeting of the Eastern Panhandle Medical Society held December 7, 1949, at Martinsburg. He discussed most interestingly the medical and technical aspects of the Washington Regional Blood Program. He stressed particularly the great need for being prepared at all times to supply all types of blood.

At the business meeting following the scientific program, Dr. Curtis G. Power was elected president, Dr. E. Andrew Zepp, first vice president, and Dr. John L. Van Metre, second vice president. Dr. G. O. Martin was reelected secretary-treasurer. Dr. Max Oats was named a member of the board of censors.—G. O. Martin, M.D., Secretary.

FAYETTE

At the regular monthly meeting of the Fayette County Medical Society held December 5, 1949, at the Hamilton Cafeteria in Montgomery, Dr. E. V. Nutter, of Gauley Bridge, was elected president for 1950. Dr. T. C. Sims, of Fayetteville, was named vice president, and Dr. DeWitt Peck, secretary-treasurer.

Drs. J. M. Jarrett and R. A. Updike were elected delegates to the House of Delegates, and Drs. T. Kerr Laird and W. B. Davis, alternates. Dr. J. B. Thompson was named a member of the Board of Censors.

It was ordered that the Chesapeake and Potomac Telephone Company of West Virginia be requested to separate the names of doctors of medicine from the names of doctors of osteopathy appearing in the classified section of its directory.—W. E. Bundy, Jr., M. D., Secretary.

* * * *

GREENBRIER VALLEY MEDICAL SOCIETY

Dr. James P. Baker, of White Sulphur Springs, was elected president of the Greenbrier Valley Medical Society at the regular meeting held in December, 1949.

Dr. J. O. Williams, of Alderson, was elected vice president, and Dr. Claude L. Houck, of Lewisburg, secretary. Dr. H. B. Strader, of White Sulphur Springs, was named delegate to the House of Delegates, and Dr. James P. Baker, alternate.

Drs. George Lemon, of Lewisburg, Richard A. Lewis, of Rainelle, and H. H. Hancock, of Union, were elected to membership in the Society, and Dr. Philip Oden was accepted as a member by transfer from the Fayette County Medical Society.—R. M. Ferrell, M. D., Secretary.

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LOGAN

Dr. Walter E. Brewer, of Logan, was elected president of the Logan County Medical Society at the regular monthly meeting held in that city December 14, 1949, succeeding Dr. I. M. Kruger.

Dr. W. P. Hamilton, of Chapmanville, was elected vice president, and Dr. Charles H. Hagen, Jr., of Holden, secretary-treasurer.

Dr. H. H. Farley, of Logan, was elected to honorary membership in the society.—Frank R. Jamison, Secretary.

* * * *

MARION

Dr. L. Rush Lambert, of Fairmont, was elected president of the Marion County Medical Society, at the regular monthly meeting held December 27, 1949, in that city. Dr. John P. Trach was elected vice president, and Drs. George T. Evans and Leo O. Spencer, secretary and treasurer, respectively.

Dr. Seigle W. Parks was elected delegate to the House of Delegates, and Dr. Joe Yost, alternate.

Dr. A. Glen Evans, of Fairmont, was elected to membership in the Society, and Dr. J. C. Collins, of that city, was elected to honorary membership.—George T. Evans, M. D., Secretary.

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MERCER

Dr. Hampton St. Clair, of Bluefield, was elected president of the Mercer County Medical Society at the regular monthly meeting held in December at Pete's Grill, in Bluefield. Dr. R. H. Fowlkes was named vice president, and Dr. D. V. Kechele, treasurer. Dr. Frank J. Holroyd was reelected secretary for his eleventh consecutive term.

Drs. W. A. Shafer, R. G. Combs, and W. E. Copenhaver, all of Bluefield, were elected to membership in the society, and Dr. Parker Hall Lee, Jr., of that city, was accepted as a member by transfer from Albemarle County (Virginia) Medical Society.

The A Cappella choir, of Bluefield, presented a musical program in connection with the December meeting.—Frank J. Holroyd, M.D., Secretary.

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MINGO

Dr. Marion L. White, of Huntington, was the guest speaker at the regular monthly meeting of the Mingo County Medical Society, held December 16, 1949, at the Mountaineer Hotel, in Williamson. His subject was "Pulmonary Diseases," and the speaker discussed such of these diseases that are best treated by resection.

At the business meeting following the scientific program, Dr. J. Carl Lawson, of Williamson, was elected president, Dr. E. P. Stepp, of Kermit, vice president, and Dr. E. T. Drake, of Williamson, secretary-treasurer. Dr. S. G. Zando, of Williamson, was named a member of the board of censors.

Dr. Russell A. Salton, of Williamson, was elected to membership in the Society.—J. C. Lawson, M.D., Secretary.

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PARKERSBURG ACADEMY

Dr. Paul L. McCuskey, of Parkersburg, was elected president of the Parkersburg Academy of Medicine at a meeting held in December, 1949. Dr. Oliver H. Brundage, of Parkersburg, was elected vice president, and Dr. S. William Goff, of Parkersburg, secretary-treasurer.

The following were elected delegates to the House of Delegates: Drs. S. William Goff, Harold Ulch, James L. Wade, Richard Corbitt, and Richard Hamilton.

Alternates were elected as follows: Drs. Logan W. Hovis, Charles L. Goodhand, Athey R. Lutz, Dana T. Moore, and Paul L. McCuskey.—Logan W. Hovis, M.D., Secretary.

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POTOMAC VALLEY

Dr. T. T. Huffman, of Keyser, was elected president of the Potomac Valley Medical Society at the regular monthly meeting held in December, 1949. The following were elected vice presidents: Drs. P. R. Wilson,

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Piedmont; J. D. Brown, Romney; M. H. Maxwell, Moorefield; L. T. Veach, Petersburg; and O. G. Mitchell, Franklin.

Dr. H. F. Coffman, of Keyser, was reelected secretary-treasurer.

The following resolution of respect to the memory of the late Dr. Samuel B. Johnson, of Franklin, was unanimously adopted:

Whereas, the tragic death of Dr. Samuel B. Johnson removes from our Society one of its most beloved and outstanding members, associated with us for the past 50 years, a faithful attendant at our meetings, a wise counsellor, broad in his views, charitable to all, no matter what cult, and a real lover of nature; and,

Whereas, we feel that by his death we have lost a valuable member, colleague, and a true friend; his clientele, a real family physician; the profession at large, a scholarly, ethical associate:

Therefore, Be It Resolved, That, while we shall miss his friendly and wise counsel and deeply regret his passing, we have profited by his association, and extend our sympathy to his family; and,

Be It Further Resolved, that a copy of these resolutions be sent to his family and spread upon the minutes of this Society.—Harry F. Coffman, M.D., Secretary.

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RALEIGH

At the December meeting of the Raleigh County Medical Society, the following officers were elected for 1950; President, Clyde A. Smith, M. D., Raleigh; Vice president, Wade H. Rardin, M. D., Beckley; and secretary-treasurer, Paul E. Vaughan, M. D., Beckley.—Wallace B. Lilly, M. D., Secretary.

WOMAN'S AUXILIARY

WA EXECUTIVE BOARD

The spring meeting of the Executive Board of the Woman's Auxiliary to the West Virginia State Medical Association will be held April 11, 1950, at the Chancellor Hotel, in Parkersburg.

EASTERN PANHANDLE

The regular luncheon meeting of the Woman's Auxiliary to the Eastern Panhandle Medical Society, was held December 14, 1949, at the Shenandoah Hotel, in Martinsburg. Reports were submitted by the chairmen of standing committees, and a musical program followed a book report given by Mrs. J. Dudley Shaw. —Mrs. John H. Kilmer, Corresponding Secretary.

* * * *

FAYETTE

Dr. Peter Ladewig, pathologist at Laird Memorial Hospital in Montgomery, was the guest speaker at the regular monthly luncheon meeting of the woman's

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Auxiliary to the Fayette County Medical Society, held January 3, at the home of Mrs. M. A. Moore, in that city. Doctor Ladewig recounted most interestingly his experiences in Turkey while associated with the University in Istanbul.

Hostesses assisting Mrs. Moore were Mrs. C. W. Stallard, Mrs. Raymond Updike, Mrs. H. C. Skaggs, and Mrs. Ralph Hogshead.—Mrs. William L. Claiborne, Corresponding Secretary

* * * *

KANAWHA

The annual Christmas party for children, grandchildren, and friends of members, sponsored by the Woman's Auxiliary to the Kanawha Medical Society, was held December 3, 1949, at the Village Theater, in Kanawha City. Admission to the all-cartoon show was a gift or toy labeled as to age and size of child.

More than 100 toys were collected and turned over to the Child Welfare Division of the Department of Public Assistance to be distributed to needy children.

Mrs. J. E. Grace and Mrs. Tracy Spencer were co-hostesses, and they were assisted by several members of the Auxiliary.

The January, 1950, meeting of the Woman's Auxiliary to the Kanawha Medical Society took the form of small morning coffees. The meeting served a two-fold purpose, one enabling members to become better acquainted, and the other making it possible to replenish the clothing chest the Auxiliary maintains for the Department of Public Assistance. Over sixty members attended the coffees, and 432 items of clothing were distributed. Where needed, the clothing was mended at the time, and all items were in wearable condition when turned over to the DPA.

Since the clothing chest idea was adopted in 1949, the Auxiliary has contributed over 700 items of clothing, thus enabling many under-privileged children to attend school.

Hostesses serving refreshments were Mesdames P. A. Tuckwiller, A. C. Chandler, Bert Bradford, Jr., J. E. Rucker, Hunter Boggs, Geo. F. Grisinger, Sr., and Earl Peck.—Mrs. V. L. Peterson, Corresponding Secretary.

* * * *

MINGO

Organization of the Woman's Auxiliary to the Mingo County Medical Society was completed on January 11, 1950, with the election of Mrs. J. Carl Lawson, of Williamson, as president. Mingo is the fifteenth auxiliary to be organized in West Virginia.

Mrs. E. T. Drake, of Williamson, was named president elect, Mrs. W. W. Scott, vice president, Mrs. Henry C. Hays, recording secretary, and Mrs. Frank J. Burien, treasurer. All of the officers reside in Williamson.

The organization was the result of an invitation from Dr. J. C. Lawson, president of the Mingo County Medical Society, to Mrs. Ross P. Daniel, of Beckley, organization chairman and president elect of the state Auxiliary, to attend a dinner meeting of the Society

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on January 11. At that time the Society authorized the organization of the local chapter and pledged full cooperation.

The twelve charter members were Mesdames J. C. Lawson, E. T. Drake, H. C. Hays, Frank J. Burien, S. G. Zando, R. C. Lawson, R. A. Salton, Jr., J. E. Caton, W. S. Feldman, W. W. Scott, J. W. Donovan, and Ernest McClellan.

Mrs. Ross P. Daniel supervised the organization of the new Auxiliary and presented an excellent address concerning the objects and purposes of a county Auxiliary.—Mrs. Henry C. Hays, Recording Secretary.

* * * *

OHIO

Members of the Ohio County Auxiliary participated actively in the drive for the Red Cross and Community Chest, and in the sale of TB seals.

During the holidays, the name of a needy family was obtained from the Community Chest. Warm clothes and shoes were presented to each of the five children and the mother, and food and toys for the smaller children were included. In addition, the Auxiliary outfitted and paid weekly and yearly dues for a girl scout from the Children's Home.

A "bundle tea" was held the middle of January, and each member of the Auxiliary brought a bundle of clothes to help fill the almost depleted "Clothes Chest."

"Doctor's Day" will be observed March 30, 1950.—Mrs. W. C. Ackerman, Jr., Corresponding Secretary.

PARKERSBURG ACADEMY

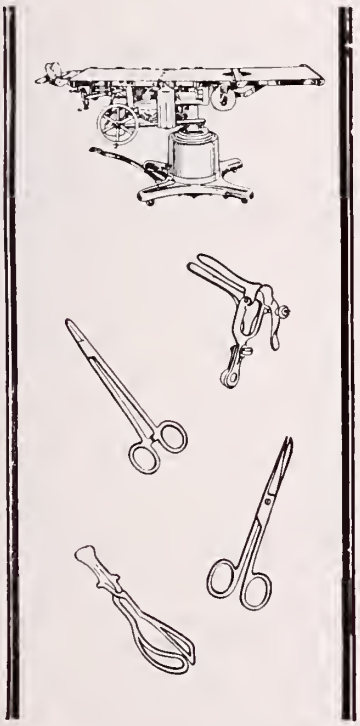
Dr. Frank J. Holroyd, of Princeton, chairman of the public relations committee of the West Virginia State Medical Association, was the guest speaker at the regular monthly luncheon meeting of the Woman's Auxiliary to the Academy of Medicine of Parkersburg, held January 10, at the Chancellor Hotel, in that city. He presented a most interesting paper outlining the growth of socialized medicine in England and the United States, and the effect of socialized medicine in England on the medical profession and the people of that country generally.

Members of the Marietta, Ohio, Auxiliary were guests at the luncheon, and Mrs. M. A. Santer, president of the Parkersburg Academy, presided as chairman. Hostesses were: Mesdames A. M. Jones, Richard Corbitt, George H. Bateman, Thomas L. Harris, Robert Lincicome, and Robert Widmeyer.—Mrs. S. William Goff, Press and Publicity Chairman.

* * * *

RALEIGH

The members of the Woman's Auxiliary to the Raleigh County Medical Society will be hostesses at a tea on March 20, 1950, for the thirty-one high school girls in that county who have indicated that they are interested in following a nursing career. Mothers and guardians of the girls, and the nurses at the Beckley and Raleigh General Hospitals will also attend the tea. Mrs. L. D. Houser will be principal speaker for the occasion.—Corresponding Secretary.



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BOOK REVIEWS

DIAGNOSIS AND TREATMENT OF BRAIN TUMORS AND CARE OF THE NEUROSURGICAL PATIENT—By Ernest Sachs, M. D., Research Associate in Physiology, Yale University, New Haven, Conn., and formerly Professor of Clinical Neurological Surgery, Washington University School of Medicine, St. Louis. Pp 552, with 348 illustrations, 10 in color. Second Edition. The C. V. Mosby Co., St. Louis. 1949. Price $15.00.

This single clinical volume is a revision of an earlier book by Doctor Sachs on "The Diagnosis and Treatment of Brain Tumors" and is combined with his previous book on "Care of the Neurosurgical Patient."

The subject matter of both volumes has been rather completely revised and brought up to date and includes the newer methods of diagnosis and treatment and such newer developments in neurosurgery as the technique of study and surgery of intracranial aneurysms and electroencephalography. However, one is disappointed at finding no reference to the Torkildsen procedure of Ventriculocisternostomy which has established its place in the palliative treatment of certain slow growing tumors which block the Aqueduct of Sylvius. This procedure is even of greater value in certain acquired strictures of the Aqueduct.

The book is based on the clinical volume and long teaching experience of the author extending over a period of some thirty-seven years during which time he has occupied a most highly respected position in his field, retiring last year to devote his time to research in physiology at Yale.

The author's interest in teaching neurosurgery is demonstrated by numerous case histories used for diagnostic and didactic purposes and the profusion of drawings and illustrations in the book outlining the various technical details of practically every operative procedure employed in neurosurgery. He has devoted an entire chapter to a discussion of post-operative complications and care of the neurosurgical patient, emphasizing that without the personal and meticulous after-care an otherwise brilliant surgical result may be lost through lack of attention to what may appear to be trivial details in the nursing care. Chapters are devoted to anaesthesia and closure of wounds, both highly important subjects to the neurosurgeon.

Other chapters deal with surgical anatomy and physiology, methods of examination, and general symptoms and signs of increased intracranial pressure, focal signs and cerebral tumors, and differential diagnosis between brain tumors and other conditions simulating tumors. This latter chapter is well illustrated with case histories and pertinent comment on the diagnostic problems involved.

There is a very excellent chapter on diseases of the Pituitary Gland and the important role the hypothala-

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mus plays in these glandular disturbances. This chapter represents our present knowledge of the functions of this gland, and the treatment of its disorders.

Tumors in special areas of the brain are taken up separately and their surgical pathology and treatment are discussed.

In the fifteenth and closing chapter of the book, the author reviews the progress neurosurgery has made since Sir Victor Horsley and Harvey Cushing started this infant specialty on its precarious voyage. It was Cushing's good fortune to live to see and enjoy the rather full fruition of his early efforts and dreams, made so largely possible by his own great and varied contributions and those of his disciples. And judging the future by the past, Doctor Sachs expresses the opinion that the possibilities for future improvement and developments in neurosurgery are almost limitless and thinks that glioma will either be removed through technical advances or its ravages suppressed by other means.

The book is attractively bound and printed in good type and style for easy reading. The bibliography is really the world's literature on neurosurgery and its allied subjects. There are many anatomical charts, color plates, photographs, illustrations, drawings and x-ray reproductions, all of excellent character which enables the reader to visualize the points made by the author.

The volume is intended primarily for neurosurgeons, house officers and nurses who deal with neurosurgical cases but its scope is broad enough so that the practitioner may find sufficient diagnostic aids as to enable him to derive satisfaction from his study and evaluation of a brain tumor suspect.

Altogether, this reviewer feels that Doctor Sachs is to be congratulated, that he has done a good job and has contributed a book which deserves a place in the reference library of any physician interested in neurosurgical cases.—Archer A. Wilson, M. D.

* * * *

NORMAL VALUES IN CLINICAL MEDICINE—By F. William Sundermon, M. D., Ph. D., Professor of Experimentol Medicine ond Clinicol Pothology, University of Texos Postgroduote School of Medicine, ond Assistont Professor of Bocteriology, The School of Medicine, University of Pennsylvonio. Pp. 845, with 237 figures ond 413 tobles. Philodelphio ond London: W. B. Sounders Co. 1949. Price $14.00.

A compendium of charts, tables, graphs and figures, this is an encyclopedia of normal values in medicine with the authority for, interpretation and discussion of, these values. The authors point out that theirs is a pioneer work, the object of which is to bring together in one volume the accepted normal values used in all branches of clinical medicine. They have been aided

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Personal Course in General Surgery, Two Weeks, starting April 17.
Surgery of Colon & Rectum, One Week, starting March 6, April 10.
Esophageal Surgery, One Week, starting June 5.
Breast & Thyroid Surgery, One Week, starting June 26.
Thoracic Surgery, One Week, starting June 12.
Gallbladder Surgery, Ten Hours, starting April 24.
Fractures & Traumatic Surgery, Two Weeks, starting March 20.
GYNECOLOGY—Intensive Course, Two Weeks, starting February 20, March 20.
Vaginal Approach to Pelvic Surgery, One Week, starting March 6.
OBSTETRICS—Intensive Course, Two Weeks, starting March 6, April 3.
PEDIATRICS—Intensive Course, Two Weeks, starting April 3.
Personal Course in Cerebral Palsy, Two Weeks, starting July 31.
MEDICINE—Intensive General Course, Two Weeks, starting April 24.
Electrocardiography & Heart Disease, Four Weeks, starting March 13.
Hematology, One Week, starting May 8.
Gastro-Enterology, Two Weeks, starting May 15.
Liver & Biliary Diseases, One Week, starting June 5.
Gastroscopy, Two Weeks, starting March 6, May 15.
DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.
UROLOGY—Intensive Course, Two Weeks, starting April 17.
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in the compilation of these varied data by forty-four collaborators.

The material is arranged in chapters to cover the bodily systems as well as many of the specialties of clinical medicine, i.e., "Normal Values in Cardiology," "Normal Values in Hematology," etc. It includes anatomical, chemical and physiological norms.

In a foreword by J. Harold Austin, M. D., the term "norm" is defined as the range within which normal values fall, and this definition has been adhered to in the arrangement of the material.

The chief appeal of this volume is its usefulness as a well compiled reference to the normal values used in other specialties than the one with which the particular reader may be familiar, and to those doing clinical investigation.—Paul H. Revercomb, M. D.

* * * *

AN ATLAS OF THE BLOOD AND BONE MARROW—By R. Philip Custer, M. D., Director, Laboratories of the Presbyterian Hospital in Philadelphia, Assistant Professor of Pathology, The University of Pennsylvania School of Medicine, and Consultant to the Armed Forces Institute of Pathology. Pp. 321, with 285 illustrations, 42 in color. First Edition. Philadelphia and London: W. B. Saunders Co. 1949. Price $15.00.

This book is written by an outstanding authority presenting a complete logical discussion of an important timely subject. In the first chapter he has a table of simplified terminology and nonmenclature of cells. This simplified terminology is overdue. The next chapter is devoted to a review of hematopoiesis while the next is a brief review of normal blood and bone marrow. Following that, all phases of hematology are discussed adequately to include the significant clinical findings, laboratory data, and in many cases a brief resume of therapy and management.

The author very aptly points out that any deviation from normal cell levels merely reflects an imbalance between blood formation and blood destruction and loss. He stresses the importance of an exact diagnosis, which can be arrived at only by a logical study of each case; yet all too often practitioners make only a feeble attempt to arrive at a precise diagnosis but are content to treat patients empirically. If the patient does not respond to "shot gun" therapy followed by transfusions, then a careful study of the case is done. By this time the hematological picture may be so altered that an exact diagnosis is difficult or impossible for a time.

We are in the habit of thinking of an atlas as a series of beautifully drawn colored plates with labels. This book contains many carefully done photomicrographs, with several in color. These photomicrographs are superior to hand drawn colored plates since they represent more exactly what we see and are not distorted by the "artist's touch."

No great attempt is made by the author to give cell details, and therefore this work will be of limited value to medical technologists and others. The descriptions of blood disorders are well done practically and logically. This book will prove to be of great value to those practitioners who are genuinely interested in practical hematology.—M. L. Hobbs, M. D.

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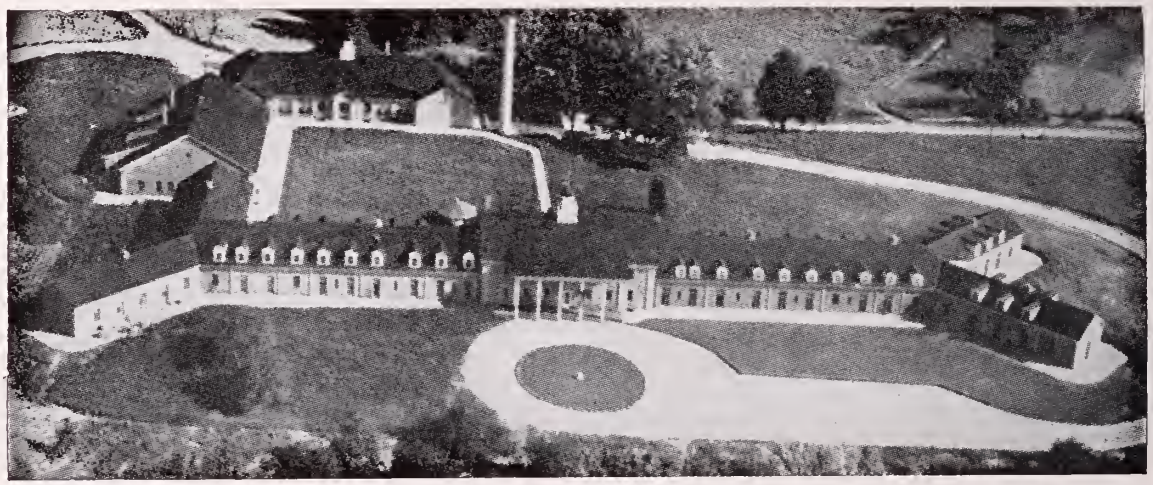

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UTERINE BLEEDING*

By R. J. WILKINSON, M. D.
Wilkinson Surgical Clinic
Huntington, W. Va.

In view of the wide scope of the subject of uterine bleeding, I shall attempt only to point out some of the more important diagnostic symptoms and findings and to suggest what we believe to be a rational method of treating these patients.

In evaluating the importance of irregular or prolonged uterine bleeding, we must consider first the patient's age and the past history. Thus, it might be well to consider these cases according to age groups, remembering that in rare instances we may be deceived by adhering too closely to any fixed rule.

Should irregular bleeding occur in a young woman with an apparently normal pelvis, we probably would think first of an endocrine imbalance and, with safety, treatment could be instituted accordingly. It has been our experience that this type of patient usually will respond to progesterone in the form of prolutin, 10 mg. daily for at least five days. This treatment should be repeated a week or ten days prior to the next regular menstrual period, and if no benefit is obtained the treatment can be safely repeated for two or three months.

Should there be evidence of thyroid or pituitary disturbance or of a blood dyscrasia, appropriate treatment should be advised since diseases of this sort exert influence upon the normal menstrual cycle and might easily be the underlying cause for excessive uterine bleeding. If after a reasonable period of time has elapsed (two or three months unless the bleeding becomes excessive) there is no appreciable improvement, a diagnostic curettage is indicated. However, I would remind you of the danger incident to this procedure and should perforation of the uterus be suspected, an immediate laparotomy is indicated.

May I stress the fact that curettage is a major surgical procedure and even when it is done by skilled surgeons perforation often occurs. Fortunately for the patient, nature comes to the rescue by sealing off the unrecognized damaged uterus. Again, it should be remembered that curettage should never be done solely as a therapeutic procedure and, further, that the scrapings often will not be of assistance in reaching a correct diagnosis. Should bleeding continue after every diagnostic method and treatment have been tried, more radical surgery is indicated. Upon exploring the pelvis, we not infrequently find an unrecognized ovarian cyst or fibroid of the uterus which can be removed without disturbing the remaining generative organs, thereby preserving the fecundity of these young women. Should myomectomy be done and there be doubt as to the uterine wall withstanding a full term pregnancy, early caesarean section often will assure us of a live baby. Here again I bring to your attention the great danger in doing unnecessary surgery upon young women. All too frequently we see the highly neurotic women who have been needlessly operated upon. Surgery has deprived them of some vital organ and contributed to their already nervous instability.

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*Presented before the West Virginia section, Southeastern Surgical Congress, Charleston, April 2, 1949.

Should you see a patient in this group who has miscarried, the diagnosis is quite obvious and the treatment simple. Only remove the remaining degenerative tissue with sponge forceps and the bleeding will be controlled.

When excessive bleeding occurs in the woman of middle age, we must keep constantly in mind the question of malignancy until proven otherwise. It is our experience that the most frequent cause of bleeding in this age group is fibroid tumor of the uterus; next in order probably is ovarian cyst with or without inflammatory change in the tubes, while endocrine imbalance and malignancies complete the picture.

In discussing this age group of those who are suffering from menorrhagia, I feel that we can follow with safety the same diagnostic procedure as outlined for the younger women. However, if treatment fails to give early results more radical surgery is advised.

In this age group we more frequently find the evasive endocervical carcinoma and, not infrequently, at too late a stage to offer any other than palliative treatment because of early infiltration into the broad ligaments. So, when doing a diagnostic curettage, be sure to obtain scrapings from this area since it is much more likely to show cancer cells than are scrapings from the fundus. In these endocervical malignancies panhysterectomy is indicated unless fixation is present in which case radium and/or x-ray therapy offers the only hope for a cure. However, it is well to remember that any form of radium therapy should be administered by a trained therapist because of the horrible sequelae that can follow the indiscriminate use of radium by doctors who were untrained.

As a diagnostic procedure, it might be well to consider the vaginal smear technic as described by Papanicolaou. However, this requires a trained cytologist or pathologist. If such a person is available, it might be well to make this study a routine office practice since malignancies of the endocervix and fundus can be diagnosed early and at a time when curative treatment can be instituted. However, a negative finding might be misleading and the examining physician must keep this in mind before passing final judgment, since the time element is of the greatest importance.

You have heard it over and over again, but I repeat that cancer must be diagnosed early if we are to offer the patient more than relief from symptoms. In discussing the question of surgery in the treatment of uterine bleeding, whether it be for a suspected fundal carcinoma, a fibroid or a uterine polyp, we are faced with the controversial question of operative procedure. Should simple supravaginal hysterectomy suffice, or should we routinely remove the entire uterus? A fairly recent study was made by a number of Boston surgeons as to the relative merits of complete hysterectomy versus supravaginal hysterectomy. It was noted that the mortality rate in the former type of operation was 2 per cent, while in the latter it was practically nil. This study is further significant because it included a very large series of patients who had been operated upon by many surgeons. When it is realized that in 1 per cent of all women who reach the age of forty carcinoma of the uterus develops, the question of procedure must be considered solely in the light of the surgeon's skill, for it would indeed be tragic if the mortality rate became elevated on routine complete hysterectomy by the pseudo-surgeon. In these cases, it has been our practice for many years, when hysterectomy seemed likely, first to dilate the cervix widely, and should cervical ulceration or a cystic condition exist, to do an electrical conization. By inserting a strip of iodoform gauze into the uterine cavity we have felt that it was a rational procedure in that free vaginal discharge from the cervical stump was provided, and we have believed that these patients have enjoyed a smoother convalescence without the painful uterine stump that many patients complain of.

By following this line of procedure for many years, we have felt that perhaps we were giving our patients every known safeguard. However, it seems that no well defined method meets every indication, for we have seen three cases in which cancer has developed subsequently in the remaining cervix and it must be agreed that this is three to many. Also, it must be considered that other patients who may have suffered a like fate may have consulted some other surgeon. This is highly probable, inasmuch as our follow-up records have been woefully neglected since the begining of the late war. The following brief history will, I think, emphasize the points that I am making and favor complete hysterectomy for these patients:

Mrs. S., age 49, consulted me relative to an enlarging abdomen. This patient had never been ill except for osteomyelitis when a young woman. Her menstrual periods had been normal until five months previously. After having missed three periods she was able to feel the growing tumor, and pregnancy was suspected. Examination disclosed a large nodular fibroid of the uterus. Surgery was advised. Following the usual procedure of dilatation, curettage and conization of the cervix, supravaginal hysterectomy was pre-

formed. One year later she consulted me with reference to irregular vaginal bleeding which had been present for a few weeks. A careful history revealed that she had been frequently taking estrogenic substance for the alleviation of menopausal symptoms. Realizing that there remained only a small cervical stump in which conization had been done, no examination was made, but rather she was advised to discontinue all medication. Since the bleeding continued, we advised curettage. The scrapings showed carcinoma of endocervical origin.

When a female who has passed the climacteric consults you with a history of uterine bleeding, the diagnosis, so far as pathologic tissue is concerned, is obvious and can mean only fibromata, polyp or malignancy. Rarely will an ovarian cyst, regardless of size, cause bleeding in patients in this age group.

If the physical findings and the Papanicolaou smear are negative, curettage is indicated because frequently we are rewarded by finding a small polyp or even a small protruding fibroid that can be removed without subjecting the patient to a more formidable operative procedure. But again, I emphasize that a negative finding must not mislead us, but rather stand out as an indication for immediate radical surgery.

The following case will emphasize the importance of avoiding delay in this type of patient:

Mrs. E., age 65, white, weight 300 pounds, was admitted to the hospital with a history of vaginal bleeding for several weeks. Examination was negative but quite satisfactory. Therefore, diagnostic curettage was done, with negative findings. Unfortunately, we failed to do a Papanicolaou smear. Bleeding continued for several weeks and, reluctantly, we advised hysterectomy. In the left horn of the uterus there was a crater which was carcinomatous, and demonstrated the inability to obtain a specimen even though we had been successful in introducing the curette into this small cavity, and had this been successful a perforation would have been inevitable. Due to this patient's size and general condition we were cowardly in not advising immediate surgery.

When a positive diagnosis cannot be made, laparotomy is indicated and should not be postponed. Obviously, complete hysterectomy is the procedure of choice unless the patient's condition is such that a prolonged operation might jeopardize her chances of recovery, or unless the condition is inoperable.

Panhysterectomy offers the patient relative freedom from subsequent surgery, and should the lesion be malignant the chances for a cure are greatly enhanced.

SUMMARY

In the treatment of uterine bleeding we stress the following points:

1. For the young woman, conservatism.
2. For the middle aged woman, establish a diagnosis even though major surgery is required.
3. For those in the older group, immediate corrective surgery.

PATHOLOGICAL DISCUSSION*

It is the task of the pathologist to determine the cause of uterine bleeding from material obtained by the surgeon. The value of tissue examination in the differential diagnosis of uterine bleeding is undisputed. Too often, however, the result of the examination will not disclose the causative pathology. It is practical and important, therefore, to discuss the failures of this method and its shortcomings as an index to rational treatment.

There are three main reasons why pathologic examination of biopsy specimens may fail to be helpful in the diagnosis of uterine bleeding:

First, the specimen may be incomplete because pertinent pathologic areas are not included even though accessible.

Second, there are difficulties in the interpretation of actual pathologic findings and their correlation with the clinical symptom of bleeding.

Third, the responsible pathology is beyond the mucous membranes lining the fundus uteri and cervix.

In so far as the first group is concerned, namely, histologic diagnosis which is of no use because of omission of pathologic material, it is clear that the pathologist can give a qualified opinion based only on the tissue he receives. In curettage, the most common procedure of biopsy of the uterus, it is not only inadequacy of surgical technic which results in failure to obtain the right specimen. There may be a small bleeding polyp, a parasitic fragment of retained placental tissue, or even a minute fundal carcinoma tucked away high in a uterine horn which may not be accessible to the curette. Not only such processes, practically hidden in a corner of the uterus, but also bleeding lesions more easily accessible to the instrument may be missed at curettage. It is very difficult to remove the entire endometrial lining through curettement. This is especially

*By S. Werthammer, M. D., Wilkinson Surgical Clinic, Huntington, West Virginia.

true in the case of the very small or very large uterus as has been illustrated by analogy by a well known teacher of gynecology. During his lecture on uterine bleeding before his students, he made a small hole in a canteloupe through which he introduced a curette. While lecturing he curetted the canteloupe continuously, removing seeds and fragments from the thin edible layer. At the end of the lecture he bisected the fruit and showed the great amount of lining left. This comparison may be extreme, but in cases in which hysterectomy has immediately followed curettage we have repeatedly seen strips and islands of endometrium, occasionally with polyps, left intact in the uterine cavity. In some of these cases the curettage had been intended to be as complete as possible.

Thus, in a small percentage of cases it will be unavoidable that the pathology which is present and responsible for bleeding does not show up in the specimen. However, such an omission is preventable if the pathology involves the endocervix. A bleeding lesion may be in the endocervical canal despite a normal exocervix. Occasionally, a correct diagnosis is made by finding among normal fundal specimens minute fragments of pathologic endocervical tissue which have been, incidentally and unintentionally, torn loose during dilatation or introduction of the curette. Granulating endocervicitis, bleeding pressure ulcers over Nabothian cysts and especially early endocervical carcinoma would not be missed if currettage of the cervix were routinely done. Preferably, curettement of the endocervical canal should precede the fundal curettement and the specimens should be separately submitted to the pathologist.

In the second group a histopathologic diagnosis loses its value if the morphologic tissue changes are improperly or not at all interpreted either by the surgeon or the pathologist. This is especially true when there is no personal contact between surgeon and pathologist as is so often the case when specimens and reports have to go by mail.

It often is impossible for the pathologist to evaluate his findings if he does not know enough about the patient. Such a simple fact as the age of the patient, for instance, makes a great deal of difference in the interpretation of a given endometrium. It is clear that an endometrium of premenstrual appearance is physiologic in a woman 25 years of age but pathologic in a woman of 65. Either the surgeon knows enough pathology to draw his conclusion from the morphologic findings in a pathologic report or there must be a certain amount of cooperation between surgeon and pathologist. A part of the cooperation consists in a minimum amount of information about the patient which can help the pathologist to rationalize histologic findings. There are especially three facts the pathologist should know about a patient with uterine bleeding in order to prevent meaningless reports.

One is the age of the patient, as mentioned previously. Using the same example as before an early adenoma malignum of the fundus in an old woman may look nearly identical with the hyperplastic premenstrual endometrium of a young woman.

Another bit of helpful information is whether or not the patient is pregnant, or has been pregnant recently, or has had an abortion. In undisturbed pregnancy bleeding lesions of and around the cervix require great care in diagnosis. It is little known, but of the utmost importance, that during pregnancy benign epithelial and mesodermal lesions of the uterus may show atypical cytology which may make them appear malignant despite their harmless nature. This is seen in fibroids; however, small papillomata and polyps of the exocervix and the endocervix may take on a suspicious appearance. Besides, in rare cases there may be decidual changes in the cervix which may be misinterpreted as epidermoid carcinoma. I know one such case of excessive decidual reaction in the cervix which even required the expert counsel of Doctor Novak to confirm its benign nature.

In uterine hemorrhage due to retained placental material after delivery or abortion the pathologist may not see in his section any significant changes. The telltale endometritis may be absent and the retained fragments so minute that they do not appear in any one section. If the pathologist knows that abortion or pregnancy has preceded the metrorrhagia, he will have many more sections prepared in order to find the guilty inclusions to make sure of the diagnosis. After all, one microscopic section is only a very thin slice of the specimen and certain structures may be outside this plane. They will be found more easily if the pathologist knows what he is looking for.

Finally, the pathologist should be told whether or not the patient is receiving or has received hormonal therapy. The importance of this information in connection with uterine bleeding often is not considered by the clinician. Even if there is no apparent connection in that the patient is not receiving estrogenic substances at the time of the currettage, a close check often will disclose that uterine bleeding started as a withdrawal symptom after discontinuation of previous hormonal therapy. Estrogenic therapy, especially in excess, may produce pathologic pic-

tures in the endometrium which are difficult to interpret at times. In addition, it may obscure, blur or modify other causative pathology of uterine bleeding. This is especially true in the postmenopausal endometrium. We have been very much impressed recently by a case of postmenopausal bleeding in which the Papanicolaou smear showed cells of the appearance of a uterine adenocarcinoma. Two other pathologists saw the same cells in repeat vaginal smears. Cervical biopsies and uterine curettage were negative and twice carried out before total hysterectomy was done. Painstaking pathologic examination did not reveal carcinoma. This woman had received rather heavy doses of estrogen. The only explanation for the discrepancy in smears and tissue sections is that estrogen modified the appearance of the cast-off endometrial cells. There is no normal cell, taken singly, which could not look like a cancer cell and vice versa. Obviously, some of the cells of the atrophic postmenopausal endometrium had proliferated under estrogenic stimulation and a few appeared like cancer cells.

In the last group of cases in which biopsy examination of the endometrium or cervix does not disclose the cause of bleeding the location of the pathology cannot be biopsied by the usual methods. Strictly speaking, constitutional diseases with uterine bleeding fall in this group. But they should be diagnosed before biopsy is taken.

There are two important intrauterine conditions which are bound to be missed by curettage. One is fibroid of the uterus. Uterine bleeding in a fibroid uterus usually is explained by pressure of the tumors on the myometrium or by the accompanying ovarian dysfunction. But we find sometimes small intramural fibroids which do not compress or distort the uterine cavity, there being no coexistent endometrial hyperplasia in these cases, yet uterine bleeding is present. In these cases the mechanism of bleeding cannot be logically explained beyond the fact that the fibroid has something to do with it.

The other condition is adenomyosis, in which there is often the symptom of menorrhagia. Here the bleeding endometrium is deeply displaced in the myometrium. Of course, this layer of the uterus should not be involved in curettage.

There are cases of uterine bleeding in which not only in biopsies but also in uterus and adnexae, after hysterectomy, no pathologic changes can be found. What caused uterine bleeding in such a case is not known though a faulty interplay of hormonal processes is assumed which is very hard to prove. These cases are puzzling but there is comparatively very little written. Last year I was shown an issue of the *New England Journal of Medicine* in which, in the classical write-ups of the clinico-pathologic conferences, a complicated case of uterine bleeding was presented. Hysterectomy had to be done finally and, as an anticlimax, the pathologic findings were that of a normal uterus. This report gladdened the heart of the surgeon who showed me the article as he had had two similar cases within a short period of time.

In conclusion, we wish to state that nobody realizes more than the pathologist how important it is to have histologic proof of a bleeding uterine lesion, most especially in malignant conditions previous to radical surgery or radiation. But the pathologist's methods have limitations resulting in diagnoses which are sometimes of no help to the surgeon. Some of these can be prevented if there exists between surgeon and pathologist enough cooperation and understanding of their methods and procedures, and their preventable pitfalls and omissions. With this idea in mind I have offered this discussion.

"PHYSICIAN, HEAL THYSELF"

A recent review of the "leading causes of death among physicians" states the final conclusion that "the medical profession is apparently giving to the general population at least as much and at least as good medical care as it is giving itself." The statistics of deaths of physicians are compared with those of the general population of similar age groups.

Among the seven leading causes of death it is rather striking that in only cancer and tuberculosis were the observed rates of death lower in physicians than in persons of the same age groups. The thought is expressed that the "physicians recognize symptoms earlier and begin treatment more promptly in cancer. It is possible that the same statement could be made about tuberculosis.

In heart and cardiovascular disease the death rate of physicians is significantly higher, and the statement seems warranted that these diseases are an "occupational hazard of the medical profession." It is possible that the present campaign about heart disease and the research program sponsored by the American Heart Association and so forth will alter this picture over a period of years.

However, the significant point is that the mortality in persons trained in medical knowledge—early symptoms, diagnosis, prevention and treatment—is no better than that of the general public in the same age groups. Why should not the physicians have a lower death rate in all diseases if they profit by their training? The natural assumption is that such trained persons could apply preventive measures, could detect earlier manifestations, could initiate early treatment and could thus prolong their span of life.—New England Journal of Medicine.

The great use of life is to spend it for something that will outlast it.—William James.

THE NEWER DEVELOPMENTS IN ANESTHESIA*

By L. H. MOUSEL, M. D.
Professor of Anesthesiology
The George Washington University
Medical School

Almost all of the major developments in anesthesia have occurred during the past twenty years. Up until that time ether, nitrous oxide, chloroform, ethyl chloride and ethylene were the agents most commonly employed. Equipment then had not been developed for efficient administration of anesthetic drugs; far too little was known about the physiologic effects of anesthetic agents; too little attention had been given to respiratory and circulatory physiology. During the 1920's physicians who were well versed in the basic sciences began interesting themselves in the science of anesthesia. Since that time many major contributions have been made which provide greater safety to patients during operation as well as make possible important advances in surgery.

Waters' adaptation of carbon dioxide absorption principals to inhalation anesthesia marks the beginning of a new era in this specialty. His technics have made possible the lung and cardiac surgery which is so common today. Following Waters' important contribution, evipal, cyclopropane and pentothal were accepted as new and useful agents. Since then few new anesthetic drugs have been added, although technics have been changed and improved to the extent that operative mortality and morbidity have been greatly reduced and surgical procedures that were only dreams fifteen years ago now have become commonplace realities.

The recent war gave great impetus to the specialty of anesthesiology. Thousands of young surgeons who served in the armed forces were for the first time given the opportunity of working with physicians who had chosen anesthesiology as their special field of endeavor and who had trained and equipped themselves in this new branch of medicine. Many young medical officers who were required to attend service anesthesia schools before joining combat organizations as anesthetists realized the importance of this phase of medical care. The vast majority of these men returned to civilian residencies after the war and are now working toward Board certification.

The anesthetist's new function as consultant in preoperative and postoperative care of surgical patients, including the management of replacement therapy, has been of far more importance than has the development of any one agent or group of agents. In many hospitals where physician anesthesiology is not available, the burden of preoperative and postoperative care falls upon the relatively inexperienced intern and resident staff. The average busy surgeon lacks time to adequately supervise the therapeutic regimen so necessary during the first forty-eight hours of any patient's hospitalization. Anesthesiologists as a group have trained themselves to be keen observers. They are equipped to evaluate the complicated problems which may and frequently do arise in connection with respiratory and circulatory disorders.

Technics providing advantages to patient and surgeon alike have influenced the care of all surgical and obstetrical patients. Lemmon's[1] technic of continuous spinal anesthesia makes possible long surgical procedures without the necessity of using the more toxic spinal agents. Tuohy's adaptation of the catheter technic of producing continuous spinal anesthesia is an improvement which has largely eliminated many of the dangers which accompanied the presence of a needle in the subarachnoid space over prolonged periods of time. Many surgical procedures, especially radical resections of the colon, probably can be done more safely with the patient under spinal anesthesia than with any other method.[2] Any prolonged surgery within the abdomen which necessitates the use of spinal anesthesia can be accomplished more safely with the use of the continuous method because the level of anesthesia can be accurately controlled when small repeated doses of the anesthetic agent are used.

Segmental anesthesia can be produced and controlled easily by the use of the catheter technic. A catheter is advanced in the subarachnoid space to any position desired and a band of anesthesia can be produced without serious interference with the sympathetic innervation and muscular tone of the lower extremities.[3] This technic is of great importance in the management of poor risk patients, especially the group of diabetic parturients for caesarean section. In such instances the fetus can be removed with only a minimum change in the mother's circulatory system and carbohydrate metabolism. The use of continuous spinal technic has been reported as an important therapeutic measure in the treatment of some anurias.[4] With the catheter advanced to the level of the 9th or 10th dorsal vertebra, extremely small doses of procaine are injected in order to paralyze the sympathetic innervation to the kidneys and to increase filtration pressure.

Continuous caudal analgesia, first reported by Hingson and Southworth[5] has been an important

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contribution, especially in the management of premature deliveries and in the management of severe toxemia of pregnancy.[6] It is possible to manage long, difficult labor in the mother who is about to deliver a premature infant without the use of depressant drugs which might jeapardize the infant's chance of survival. This method, when used in the eclamptic mother, usually reduces blood pressure to somewhere within normal limits and prevents convulsive seizures. It is important to continue administration of the analgesic agent into the sacral canal for several hours following delivery of the fetus in order to prevent postpartum convulsions.

Saddle block anesthesia for the obstetrical patient is satisfactory and relatively safe as long as small doses of the anesthetic drug are used and specific technics are carefully followed. This method for obstetrical analgesia probably can be the safest of all in an obstetrical practice where a well trained anesthesiologist is not available. The technic first described by Adriani advocates a small dose of nupercaine in a solution of 5 per cent dextrose. Subarachnoid injection is made at the level of the 4th lumbar interspace with the patient in the sitting position.

The solution is injected slowly and the patient is kept in the sitting position for approximately 30 seconds following administration of the drug. Care is taken not to inject during active uterine contractions because it has been found that by so doing anesthesia may rise to a dangerously high level. Thirty seconds after the injection, the patient is allowed to assume a supine position. In many instances, satisfactory analgesia will be present for as long as three hours.

Satisfactory saddle block analgesia can be produced using less toxic agents such as pontocaine-procaine mixtures or procaine or metycaine alone. At The George Washington University Hospital dextrose is not injected into the subarachnoid space to produce saddle block analgesia in cases in which prolonged analgesia is desired. We use a combination of 5 mg. of pontocaine and 25 mg. of procaine diluted in 1½ cc's. of spinal fluid. The technic is the same as that described by Adriani. In cases in which only short periods of analgesia are desired, good results can be obtained by dissolving 75 to 100 mg. of procaine crystals in 1½ to 2 cc's. of spinal fluid. Again, injection is made slowly with the patient in the sitting position. This method usually will provide one to 1¼ hours of analgesia.

Of the newer anesthetic agents, pentothal sodium, first investigated clinically by Lundy,[7] has proved to be the most important contribution in the field of anesthesiology since 1930. This agent has gained widespread use as the sole anesthetic agent in many minor surgical procedures as well as in combination with other agents, when balanced anesthesia is desired. Relatively short procedures usually can be carried out safely by following the intermittent method of administration, bringing the patient to the desired level of anesthesia. Longer procedures not requiring muscular relaxation can be done using combinations of pentothal sodium given intravenrously along with the simultaneous administration of nitrous oxide, ethylene, or cyclopropane. Pentothal as a sole agent usually is not satisfactory for prolonged operations requiring profound muscular relaxation. While it has been used for this purpose, the amount of drug required to produce ideal operating conditions may result in severe respiratory depression during operation and a prolonged period of postoperative narcosis.

Pentothal sodium is ideal for induction prior to the administration of other agents by the inhalation method. Most patients who come to the operating room are somewhat apprehensive in spite of preoperative administration of sedative drugs. The placement of an anesthesia mask on a patient's face frequently increases apprehension and quite often results in a marked excitement period. During the past year at The George Washington University Hospital almost every surgical patient has been given the benefit of pentothal induction preceding the inhalation anesthetic. Under most circumstances, patients are brought to the operating room lightly sedated, placed on the operating table, and a needle inserted in a convenient vein. An active conversation then is carried on and during this time a sufficient amount of pentothal is given, without warning to the patient, to produce an unconscious state. Pentothal is then administered by the intermittent method until the lid reflex disappears, at which time the anesthetic mask is placed on the face. Gas and oxygen are then administered for a few minutes, then ether gradually is added to the mixture. Pentothal administration is continued until the patient has inhaled a sufficient amount of ether to insure first plane of third stage anesthesia. When this type of induction is done, excitement stages are almost never observed and there is little, if any, alteration in the circulatory system.

Extremely nervous and apprehensive patients usually are given pentothal in their rooms before they are taken to the operative suite. Deep narcosis is neither necessary nor desirable under such circumstances. If the patient is given enough of the anesthetic drug so that he has difficulty in answering questions, one can be assured that he is in a completely amnesic state and will not re-

member his trip to the operating room nor his anesthetic induction. As a precautionary measure, oxygen is always taken to the patient's room when this type of basal amnesia is employed.

The use of curare and curare-like compounds to produce profound muscular relaxation was first reported clinically by Griffiths[8] in 1942. Since that time various curare preparations have been used clinically, chiefly in cases in which the anesthetic agent being used cannot be depended upon to produce satisfactory muscular paralysis without taking the patient into a dangerously deep stage of anesthesia. It must be remembered that this drug is not an anesthetic nor an analgesic agent. Smith,[9] of Salt Lake City, who allowed experimentation on himself, proved conclusively that this agent has no significant central stimulant, depressant, nor analgesic action.

Although curare is being rather widely used in conjunction with pentothal as a sole anesthetic agent, it is my belief that this combination ought to be avoided. Both drugs tend to produce bronchial constriction and the combination of the two agents being given simultaneously may result in severe bronchial spasm.

Curare, given simultaneously with the administration of cyclopropane, is said to produce ideal operating conditions. Here again we are dealing with two agents which tend to produce bronchial spasm. If such administration is to be carried out, careful histories should be taken in order to avoid the administration of these two agents to those patients having a history of asthma. If curare is used with ether, pentothal, or cyclopropane, careful attention must be given to the patient's tidal volume, for the combination of these agents frequently results in severe respiratory depression necessitating active support of respiration until all evidence of depression has been eliminated.

Curare preparations can be used safely in conjunction with ether anesthesia. There is little danger of bronchial spasm in these patients, for ether has a paralyzing effect on bronchial musculature. If this combination is used, small doses must be given itermittently in order to obtain the result desired without severe reduction in tidal volume or respiratory paralysis. Most of our modern inhalation anesthesia methods will produce satisfactory operating conditions without the use of curare. We must never allow ourselves to use this drug as a substitute for good anesthesia.

The technics of sympathetic nerve block, used for both diagnostic and therapeutic purposes, have been developed and greatly improved upon by anesthesiologists during the past ten years. Many patients suffering from vascular diseases such as arterial or venous thrombosis can be greatly benefited by the interruption of impulses through the sympathetic nerve supply of the area involved. The use of stellate ganglion block in the treatment of cerebral thrombosis has been a fairly recent development. Certainly its early use following certain cerebral vascular accidents offers the physician a new therapeutic weapon. Many patients suffering from trigeminal, cervical and intercostal neuralgia can be improved and occasionally pain can be entirely eliminated by nerve block procedures.

The anethesiologist's function in preoperative and postoperative care, his knowledge of fluid balance and replacement therapy, and his keen understanding of pulmonary complications which frequently develop following operation, probably have been his greatest contribution to patient care. Many cases of early atelectasis can be diagnosed and treated adequately by conservative measures. When conservative measures fail, bronchscopic aspiration is resorted to.

Dittrick[10] sums up the anesthetist's contribution to surgery by saying: "Only one who has witnessed the surgery of a generation ago can appreciate the changes that have occurred. . . . The patients exhibit no sign of fear. Nowhere is there evidence of the noisy struggling and retching of patients in the stimulating stage of anesthesia. . . . Possible complications had been anticipated and proper measures taken to forestall them. . . . The surgeon is wholly absorbed in the technic of the operation. The anesthetist is responsible for administration of necessary medication if any unfavorable symptoms develop. It is even his duty to introduce blood or blood substitutes. Through a division of labor a smoother working of the surgical team has been developed. . . . Work is lighter on the ward for the patients are less shocked, require less treatment, and there is less commotion round about them. Then, too, since they are not as sick as the postoperative patients of a generation ago, they are able to sit up in bed within a day or two after operation and are promptly discharged from the hospital."

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SPEAKING OUR LANGUAGE

The question is and has been for many many years in Mississippi: When a four-year medical school?

We have had a good two-year school for about forty-five years, but have been unable to cross the line and go to a full unit. It is hard to conceive just why. There certainly is not that much difference in the cost; even if there were, it is time we quit renting and working on the halves medically speaking and have our own school.

Our schools are about twenty per cent short of room in this country. We must enlarge them or put in more schools. We think it better for us to add another good four-year school. Some say we have more medical schools and doctors than other countries now. So we do; so we do also have more automobiles than any other nation. The people of this country are using more medical service and using it to a good advantage.

The United States is the big brother of the world now in many respects and certainly in medical education. Many doctors from other countries are and will be coming to the United States for postgraduate work. We need to receive them in our larger medical schools. We think Mississippi should educate enough young men to supply our own state with doctors and to have some to go out to other sections to practice democratic medicine; we provide plenty of manpower to do almost everything else.

If our state can have one of the best two-year medical schools for nearly a half century, the best health department in the United States, the best system of junior colleges, can lead in pulpwood and pecan and tung oil production, can rank third in lumber, build the best system of arterial roads in the nation, and offer the best location in the nation for a medical school in the fastest growing city in the Deep South, while promising an income of eight million dollars per year from oil, it can have a four-year medical school to turn out practical medical men who can serve us better than any from Long Island or California.

We need medical vision and the courage to go ahead. And while all the pressure groups are lining up to call on the legislature, it is time for the friends of the four-year medical school to get busy and keep busy. We have no further patience with any man who is against a four-year medical school for our state and it is time for action. It is time for doubters to be for a medical school.—The Mississippi Doctor.

PLASTIC SURGERY IN OPHTHALMOLOGY*

By BYRON SMITH, M. D.
New York, N. Y.

Reconstructive surgery about the eye and orbit is of interest to the general plastic surgeon, the otorhinolaryngologist, the neurosurgeon and the oral surgeon, as well as to the ophthalmic surgeon. The order in which these specialists are called into consultation varies with the circumstance of the individual case, the qualifications of the surgeon in charge and the availability of consultants. So complex are the anatomy of the orbit and the complications which may enter into the clinical picture, that a cooperative team frequently is the best means of analyzing the problem. Realization of the limitations of one's experience, knowledge and ability affords the ophthalmologist the rational judgment required to ask for help when necessary. We have long since outlived the day when personal pride and professional jealousy are permitted to militate against the progress of a healing wound.

ANATOMICAL SURVEY

Surface anatomy depicts the natural lines in which scars may be concealed. Creating lost natural folds and transplanting cilia frequently add a fraction to the problem of reconstructive surgery about the eye. General surgery decrees the removal of hair from the surgical field before surgery is attempted. About the eye and brow, it is occasionally necessary to operate in the presence of cilia to maintain proper alignment. From experience, it is known that surgery in the orbital region is well tolerated in the presence of hairs provided the wound surfaces are free from hairs and foreign material.

The origin and insertion of muscles and the position of the nerve supply must be constantly kept in mind for the preservation of cosmetic continuity, muscular tonicity and subsequent functional activity. The superficial blood supply in the region of the orbit is so voluminous that various small vessels may be sacrificed without jeopardy to the healing process.

A study of the vertical cross section of the lid clearly exhibits a line of surgical cleavage between the "skin muscle" and the "tarsoconjunctival" layers. Splitting the lid along the grey line of the tarsal margin determines the two distinct layers which may be used as advancement flaps for transposition to the same or opposing lid.

Absence of function or lack of continuity in the levator palpebrarum superioris initiates the

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deformity of blepharoptosis. Familiarity with the anatomy of this muscle offers little assurance of its absolute recognition. Under the best of circumstances, the levator is difficult to identify. The use of local anesthesia and voluntary contraction of the proximal portion of the muscle is a helpful means of orientation in a perplexing area of hemorrhage and edema.

The anatomy of the internal canthal ligament and its relationship to the lacrimal draining mechanism are of great importance in avoiding post-traumatic ectropion, canthal displacement and lacrimal stenosis. The bony walls of the orbit present numerous important orifices and house the cavities of the paranasal sinuses and brain. Small innocent-appearing external wounds may involve any of the periorbital cavities. Particularly is this significant in wounds of the upper lid which may communicate, through the thin roof of the orbit, with the brain.

The deep circulation of the orbit and the alliance of the internal carotid artery to the caverous sinus underlie the background of the arterio-venous communication. Knowledge of the anatomy of the globe, extra-ocular muscles and the corresponding nerve supply is a surgical prerequisite so obvious that mere mention is sufficient.

EARLY SIMPLE LACERATIONS

Wounds through the lid margin have a tendency to heal with a permanent residual notch unless precautions are taken to avoid the deformity. If the laceration is single, also vertical to the lid margin, a convenient means of repair is the halving operation popularized by Wheeler. The technic is executed by means of dissecting an overlapping joint as is done in splicing a timber. On one margin of the wound a small section of the "skin muscle" layer is excised and on the opposite wound edge an identical section of the "tarsoconjunctival" layer is resected. The wound is closed with a through and through mattress suture in addition to auxiliary suturing of the wound edges. It is an excellent means of repairing a lid laceration; however, it requires a sharp knife, skill and considerable time. It has the disadvantage of slightly shortening the horizontal length of the lid. The necessary shortening is negligible unless multiple lacerations are present.

Wheeler's technic has been modified by Hughes, who creates a dovetail or V type vertical tongue and groove joint supported externally by a small skin overlap advancement flap. A single mattress suture is inserted completely through the various layers to exact the proximity of the tongue to the groove. Interrupted fine sutures are placed to accurately approximate the exposed wound edges.

A more simple means of closing a lid laceration is the application of a vertical figure of eight suture placed in the plane of the grey line of the injured lid through the grey line of the opposing lid and tied outside of the skin over a small rubber plate or baby button. This suture insures close contact between the wound edges, and supports the severed lid margin against the flat edge of the adjacent lid. The figure of eight suture is indicated when lacerations are multiple or in situations in which a sacrifice of horizontal lid length is not justified.

LATE WOUNDS OF THE EYELIDS

Lacerations involving the canthal ligaments require the construction of a tarsal tongue as a ligamentous substitute for periosteal attachment. If this technic is not performed colobomata ectropion and epiphora invariably result. An attempt should be made to canalize the canaliculus with a braided silk suture which is passed into the lacrimal sac and out through the overlying skin. The suture is left in place and may be used as a wick until epithelization is complete. The continuity of the canaliculus is worth striving for; however, it is not as important as over-correcting the position of the lid in the hope that a coloboma may be avoided.

Due to various circumstances, wounds of the eyelids frequently are not seen until several days have elapsed. During the first ten days, it is possible to minimize edema and infection by wet dressings and systemic therapy using antibiotics. Within twenty-four to forty-eight hours following the institution of supportive and antibiotic therapy, delayed primary closure frequently is possible. This regime may shorten the period of hospitalization, and minimize debility and residual deformity. Conservation of all viable fragments of tissue during wound preparation is a necessity if material for achieving anatomical continuity is to be available. Tissues completely separated from the blood supply may be utilized as free grafts if properly managed. Bone fragments with attached periosteum should be preserved for replacement to their origin. Although it is impossible to close a wound completely in the presence of tissue loss, it is imperative to maintain the normal position of the remaining structures. Terminal fragments of lid may be held in normal position and prevented from contracting by creating adhesions to the opposing lid. Fragments of sclera from a disrupted globe are picked up on a continuous suture before excision. Raw areas which cannot be closed should

be covered with a thin split thickness skin graft dressing. After epithelization is complete and the scars have softened, definitive reconstruction is in order.

LOSS OF LID SUBSTANCE

It is convenient to divide arbitrarily the transverse axis of the eyelids into thirds for the purpose of reference, namely, the nasal third, the middle third and the temporal third. In the discussion of anatomy, the anteroposterior diameter of the lid was divided into the two natural surgical layers by splitting the lid just superficial to the tarsus. In the presence of lid tissue loss, it is logical to refer to the defect as a loss of the descriptive third or thirds of the lid and to mention the presence or absence of the "skin-muscle" layer, or "tarsoconjunctival layer", or both. If only one of the two surgical layers is absent, the surgical challenge is less difficult than if both layers have been destroyed.

Simple replacement of the "skin-muscle layer" only, presents the surgeon with the alternative of a local flap created by sliding, rotating, advancing and transposing or a free graft. The local flaps may arise from the surrounding skin of the same or opposing lid. Provided that the circulation of the adjoining "tarsoconjunctival layer" *is not* disturbed, the election of a free skin graft instead of a circulating flap may be the procedure of choice. Free full thickness grafts of normal lid skin, because of their consistency and color, are preferable to grafts taken from other sites. The second best donor site is the cephalo-auricular angle. As a third choice, the skin of the supraclavicular triangle is preferable. Prepuce skin may be used if the other donor areas are not available. A split skin graft taken from a non-hair-bearing area offers the last choice of a donor site. Full thickness grafts from the abdomen, chest or extremities are too thick for lid skin substitutes. Particularly is this true of the upper lid recipient area. Skin from the trunk and extremities may be used as a free split thickness graft but the color usually is too pale in members of the white race and too dark in those of the colored race.

In the presence of infection, the viability of a split thickness graft surpasses the tolerance of a full thickness graft. Postoperative contracture is inversely proportional to the thickness of the graft. For example, the amount of postoperative shrinkage is less in full thickness grafts than in split thickness grafts. Thin split thickness grafts are preferable over large areas of denudation where infection flourishes, as is seen in early burns. The shrinkage and color matching may be subsequently rectified by secondary surgery and tatooing.

For replacement of the "tarsoconjunctival" layer, the determining factor in the choice of a free or circulating graft rests in the presence or absence of circulation in the adjacent "skin-muscle" layer. If circulation *is not* present in the overlying "skin-muscle" layer, a circulating sliding, advancement, rotation or transposition flap of tarsus or conjunctiva from the same or opposing lid is indicated. Provided that circulation *is* present in the overlying "skin-muscle" layer, a free tarsal graft from the opposite upper lid may be used to replace the deficient tarsus. Conjunctiva may be replaced by a free conjunctival graft from the contralateral or homolateral superior fornix. If conjunctiva is not available, mouth mucous membrane supplies a substitute. The infection present in the buccal or vaginal mucosa is well tolerated by the eye but the grafts are not as pliable as normal conjunctiva. For free tarsal grafts in the absence of available donor tarsus, one may use ear cartilage to which a subcutaneous implant of mouth mucous membrane has been pregrafted. The ear cartilage with its adherent mouth mucous membrane may be transplanted to the eyelid according to the technic required in free tarsal grafting. The cornea will not tolerate epidermal cells as a substitute for conjunctiva.

To Hughes, the profession is indebted for his interest in blepharopoesis and popularization of the double circulating flap in eyelid reconstruction. According to the technic he describes, defects of any part or all of either lid may be replaced. The degree of scarring by this technic is much less than that created by large flaps and skin tubes described by other authors.

ECTROPION AND ENTROPION

The majority of blephoral ectropion deformities result from cutaneous or subcutaneous cicatrization. Over exposed conjunctival surfaces, there is a tendency toward ulceration and keratinization. The deformity also frequently has a tendency to elongate the transvere length of the lid margin and shorten the vertical axis of the lid. As a secondary manifestation, exposure keratitis may develop in the cornea. Protection of the cornea frequently rests in the requirement for interpalpebral adhesions. The corrective surgery of ectropion depends upon the removal of scar tissue, the freeing of the vertical cicatricial bands, the overcorrection of the vertical expanse of the eyelid, the excision of excess horizontal tarsal length and the grafting of the recipient lid surface. The postoperative course of a skin graft

of the eyelid seems to be more healthy under a wet dressing than a greasy or dry dressing. Until a graft is two weeks old, it is possible inadvertently to rip the graft from its bed by the injudicious handling of a dressing adherent to the graft surface. The application of a double layer of perforated cilkloid or fine mesh parachute silk dressing nullifies the adherence of the dressing.

Entropion may be due to cicatrization or muscle spasm. The surgical treatment of the former requires removal of the cicatrix, elimination of vertical lid shortening and, frequently, replacement of deficient palpebral conjunctiva. In certain cases, a wedge of tarsus or mouth mucous membrane along the lid margin is the means of eliminating the trichiasis.

In the past, treatment by various means of increasing the scar tissue content of the lid have been advocated in the hope that additional scar may pull in the desired direction. Such cauterizations and cicatricial stimulants frequently add insult to injury. In any event, scar tissue is added to an etiologic cicatrix.

Spastic entropion may be treated with novacaine or alcohol injections. In the majority of instances, injection therapy is of only temporary benefit. A surgical technic for the treatment of spastic entropion by shortening a band of orbicularis muscle was described by Wheeler. He used two means of shortening the strip of orbicularis. One procedure was done by overlapping the severed ends of the band of muscle in the middle third of the lower lid. An alternate procedure was done by suturing the temporal end of the muscle strip to the periosteum subjacent to the insertion of the external cathal ligament.

A small percentage of spastic entropion cases treated by the Wheeler technic terminate in no correction of the entropion, or result in cicatricial ectropion. Overlapping of the muscle in the middle third of the lower lid seems to predispose to ectropion. Undercorrection and recurrence of the entropion is prone to occur in the presence of slight degrees of enophthalmos. The solution has been suggested and demonstrated by Hughes. The technic consists of dissecting the identical strip of orbicularis muscle but differs in the location of suturing it. After the temporal end of the muscle strip is freed, it is carried inferiorly and temporalward where it is sutured to the periosteum overlying the external inferior angle of the orbit. The diagonal direction of muscle pull has eliminated complications and has resulted in no known failures.

THERMAL BURNS OF THE EYELIDS

A burn is a toxic wound resulting from a thermal, solar, chemical, electrical or roentgen stimulus. In this discussion our concern is limited to fire burns. Regarding the depth of an eyelid burn, one may use the general classification of first, second, or third degree. As to distribution of burned area, flame burns are characterized as military, civilian, or epileptic. Military burns from gasoline, various forms of flash, and burning aircraft, usually involve the extensor surfaces of the hands, the entire face and ears. Burns from civilian accidents usually burn the flexor surface of the hands and the neck beneath the level of the mandible and spare the face and ears. Epileptics tend to fall into the fire, distributing the burn over one shoulder, the homolateral half of the face, the lids of one eye, half of the forehead and possibly extending as far back as the parietal region of the scalp and over the adjacent ear. Keeping these areas of burn distribution in mind, one frequently may calculate the cause of burns when casually walking through a burn ward.

Before an ophthalmologist is called into consultation to view a burn victim, the patient usually has been seen and treated by other members of the profession. Unless the patient survives, eye treatment is of little avail. It is hardly the responsibility of the ophthalmologist to supervise the supportive therapy of the burn case if a general surgeon is in charge. However, suggestions from the ophthalmologist usually are taken kindly enough that one is obliged to observe the laboratory sheet, protein balance, dietary intake and actively engage in the fight against infection.

A burn is a very sensitive wound which is present on the body of an individual suffering mentally and physically from the experience of having been burned. Through the period of convalescence, recovery from mental trauma may fall behind the rate of physical restitution. A study of the magnitude of the wounds and the prevention of additional psychic trauma from pain is facilitated by the employment of general anesthesia. If a burn is of sufficient severity to char the eyelids and injure the cornea, the patient usually does not survive. Corneal injury most frequently is the result of exposure from contraction of the eyelids. Since edema of the lids and excessive lacrimation accompany early burns, the ophthalmologist seldom sees exposure keratitis until healing and cicatrization have advanced for at least two weeks. Accordingly, there is no emergency for suturing the lids or attempting to create interpalpebral adhesions immediately. After the lids have been treated with moist

fine mesh gauze dressing for a few days, the elimination of edema and infection are more conducive to the indicated surgery.

Due to the defective circulation and gelatinous consistency of early burned lid margins, premature attempts at creating lid adhesions result in severe damage and disappointment. If adhesions are indicated, delay beyond the optimum stage of early surgery may result in severe corneal damage. The burned areas of the lids should be grafted with thin split thickness free grafts as soon as local and systemic conditions permit. If the surgeon chooses to greatly overcorrect the vertical width of the upper lid by dissection and extension over the outside of the lower lid, adhesions may be unnecessary. The expansive recipient area is covered by a split thickness graft beneath a mold. In the choice of this technic, both upper lids may be corrected during the same operation. Correction of the lower lids should be reserved for a full thickness graft at a later date according to the technic outlined in the description of ectropion treatment. Temporary binocular dressings are beneficial in keeping the graft bed free from motion. Graduated activity after a few days has no deleterious effect upon the graft.

Epithelization of the raw surfaces prevents the progress of cicatrization. It frequently is necessary to perform secondary surgery at a later date as a means of eliminating irregularities and subcutaneous scars. Massage and emolients tend to reduce the necessity for late surgery. If interpalpebral adhesions have been established in the regime of therapy, they should remain intact until the lids have been sufficiently stretched and thus conform to a relatively normal position. As a rule, adhesions should not be incised until approximately three months after terminal resurfacing of the lid.

With the lapse of time, grafts gradually blend into the surrounding skin; scars soften and become more pliable. Tatoo or surface make-up may embellish the defects nature has failed to correct during the healing process.

CONCLUSIONS

1. Cooperation between specialists in the field of head surgery result in optimum therapy.

2. An accurate knowledge of anatomy is a prerequisite in ophthalmic plastic surgery.

3. Progress in the treatment of lacerations of the eyelids has been enhanced by experience and antibiotics.

4. Any part, or all, of either the upper or the lower eyelid may be replaced by surgical means.

5. Cicatricial ectropion and entropion are surgically correctable.

6. Hughes' modification of the Wheeler operation for spastic entropion has a tendency toward uniform results.

7. Fire burns of the eyelids demand early integrated, consistent treatment for the minimization of definitive cicatrization and deformity.

8. Psychologic rehabilitation and adjustment to residual deformity is as important as surgical technic.

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THE ACCIDENT-PRONE INDIVIDUAL

An important corollary of this new concept of the psychological factor in accidents is the responsibility of the health department in accident prevention. When we thought of the accident hazard as primarily an engineering problem, control of this hazard might porperly be assigned to the highway department and the labor department. If, as we now begin to realize, it is most often a problem of human psychology, the health department, with its medical background, is the indicated agency.

The treatment of the accident-prone individual may generally be so serious a psychotherapeutic problem as to be far beyond the range of present-day planning. The recognition of such an individual is a much simpler task; and his removal from the steering wheel of a car, or from the proximity of a dangerous machine would be a fruitful objective for the health administrator.—American Journal of Public Health.

MORTALITY IN RHEUMATIC FEVER

Rheumatic fever causes annually ten times as many deaths as infantile paralysis. Two per cent of the school children of the United States have heart disease as a result of the rheumatic fever state. The cause of at least 90 per cent of all heart disease in patients under 20 years of age is rheumatic fever. Rheumatic fever causes more deaths in the first decades of life than all of the communicable diseases plus pneumonia.—Vincent W. Koch, M. D., in Wisconsin Medical Journal.

SOME OBSERVATIONS ON MEDICAL EDUCATION AND PRACTICE IN PERU

By EDWARD J. VAN LIERE, M. D.
Morgantown, W. Va.

An International Symposium on High Altitude Biology was held at Lima, Peru from November 23 to the 30th inclusive under the auspices of UNESCO and the government of Peru. Since I have been interested in high altitude biology (anoxia) for over a quarter of a century, I felt it my duty to attend this important meeting even though it was a long way from home and a rather costly undertaking.

Miami, Florida serves as a gateway to the west coast of South America. Accordingly I boarded a morning plane in Morgantown and flew to Miami, arriving there in the late afternoon. The next morning I got on a D-C 4 which left Miami at 8:40 and which was scheduled to arrive at Lima, Peru at midnight on the same day. Short stop-overs were made at Balboa in the Canal Zone and at Quayaquil, Ecquador. There are planes that are more luxurious and faster than the one I chose, but the D-C 4 suited my purpose.

The President of the Symposium was Dr. Carlos Monge, who is Director of the Institute of Andean Biology and Professor of Medicine of the University of San Marcos. Some of the readers may recall that he was the first to describe fully chronic altitude sickness. This condition is now called Monge's Disease. He is not only a distinguished scientist, but a fine person. I am proud to state that he has been my friend for many years. He is ably assisted at the Institute by Dr. Alberto Hurtado, who serves as Research Director The latter is widely known for his researches in the field of high altitude physiology and medicine and is highly respected as a scientist and as a man.

The principal topics stressed at the Symposium were the physiology of the circulation, the blood, and respiration at rest and during work; the nervous and the reproductive systems were also considered. Considerable time was devoted also to the problem of adaption to altitude. It must be remembered that aviation medicine, and for that matter several phases of clinical medicine, are concerned intimately with problems of low oxygen tension (anoxic anoxia).

The American delegation was headed by General Harry G. Armstrong, who recently was made Surgeon General of the Army Air Force. He was accompanied by General Wallace H. Graham of Walter Reed Hospital and President Truman's personal physician. General Otis O. Benson, Director of the School of Aviation Medicine at Randolph Field, Texas was also in this party. The Navy was represented by several distinguished men from the various laboratories. Besides representatives from the Army and Navy services there were some outstanding physiologists present from various foreign countries and the United States, among them were two Nobel Prize Laureates.

The delegates to the Symposium were royally entertained. Cocktail parties were given for us at Dr. Monge's lovely home, at the commodious home of Dr. Dulanto, Rector of the University of San Marcos, and also at the Medical School. A banquet was given in our honor at the Country Club, which really was an elegant affair. It started in the early evening and lasted until after 1:00 A. M. We were also entertained at the American Embassy and were received by Ambassador and Mrs. Tittman. Our Embassy is housed in a beautiful building. I was not only proud of this, but also proud of our ambassador and his charming wife. These people made a fine impression on all of us.

Many distinguished guests attended these various social functions, such as, the Minister of Finance, the Minister of Health, the President of the University of San Marcos, the Dean of the Medical School and many of his Faculty, and also high officials of the armed forces.

Excursions were made to the famous Museum of Anthropology and Archaeology situated in Lima and a two day trip made to the three Laboratories of the Institute of Andean Biology, the highest of which is situated at Ticlio at an altitude of 16,500 feet.

MEDICAL EDUCATION

Sufficient time was not found to get all the data I desired about medical education in Peru, but I did obtain some salient facts. The information set forth here was obtained largely from an instructor in the School of Medicine and from several medical students. I met the Dean of the Medical School at several different functions, but with one exception, our talks on these occasions were mostly of a social nature. My stay in Lima was so short that I did not find the opportunity of paying him a formal visit in his office.

There is only one medical school in Peru, namely, The Faculty of Medicine of the University of San Marcos, located in Lima. This University is one of the oldest in the Americas and in 1951 will celebrate its 400th anniversary.

Two years of premedical work are required. This preliminary training may be taken in one

of the five institutions of higher learning (including the University of San Marcos), which exist in Peru. The medical course proper lasts six years and at the end of that time the student is expected to take an internship.

As nearly as I could ascertain, there are several thousand medical students enrolled. There were about 750 students in last year's freshman class; approximately 200 or so of these failed to pass all their work, so this left about 550 for the second year class. This seems like a tremendous mortality. I do not know how many fail after they have passed successfully their freshman year. I must explain that these figures were not secured from the Dean's office, but from several students, who seemed to be earnest and truthful lads.

I made inquiries about material for gross anatomy and was told that five students worked on a cadaver. When I asked why the odd number I was told that originally there were six on a body, but due to so many failures a group of only five was left. (This information was also volunteered by the students.) Since there has been a shortage of cadavers in the United States, I was anxious to know about the situation in Peru. It seems that they have an adequate supply; they are obtained from the hospitals, the sanitaria for tuberculosis, and a few from the prisons.

Since I am a professional physiologist, the laboratory work in physiology interested me. The students told me they worked on frogs, guinea-pigs, cats and dogs, in other words, just about as our students do. They told me further that they were not troubled with antivivisectionists. This is quite in contrast to the situation in this country. It gave me a high opinion of the general intelligence of the people of Peru.

Although, as previously mentioned, I did not find time to talk at length with the Dean of the Medical School, I did have occasion one evening to talk with him for a little while on medical education in general. I found the Dean to be a friendly, charming Spanish gentleman. He teaches Neuro-anatomy and comes to the United States frequently to take postgraduate work. He explained in some detail that he was elected Dean because of his seniority and not of his own choosing. He told me that next year a serious effort was to be made to cut down the enrollment of the freshman class to possibly 250 or even 200 students. The tuition for the student is quite low. I understood him to say that it was equivalent to about ten United States dollars, which in Peruvian money would be approximately 180 soles. It appears that the books and nearly all the necessary supplies are provided by the government. As far as I could ascertain, there are no full-time teachers in the Medical School; all of them are in the active practice of medicine.

Dr. Herman Weiskotten, Chairman of the Council on Medical Education and Hospitals of the American Medical Association, recently made a survey of medical education in Peru. I have not seen his report.

PHYSICIAN'S FEES

As nearly as I could judge, there are a plethora of physicians in the city of Lima, but it was emphasized that there was a shortage of doctors in what may be termed the rural areas. It would seem that the problem of distribution of physicians in Peru is similar to that in the United States. As I have explained previously, there is but one Medical School in Peru, the University of San Marcos. The majority of practicing physicians are graduates of that institution. Some of them, however, have taken their medical work in foreign Universities, (United States, Spain and other countries). Many of them, too, have taken postgraduate work outside their own country.

I made some investigation about the fees that physicians charge. It may be in order at this point to explain briefly the monetary unit in Peru. They use the term "soles" as we do dollars. Although there is no official rate of exchange, a United States dollar is worth about 18 soles. The value fluctuates, however, and while I was there the soles was worth about 6.5 cents.

I was informed that for the average office call, a charge of from $1.30 to $3.25 was made (20 to 50 soles). A house call would run between $3.25 to $6.50 (50 to 100 soles). I sought information also regarding charges made for certain laboratory procedures. The fee for a basal metabolism determination is $6.50 (100 soles) and for taking an electrocardiogram, $9.75 (150 soles). It will be noted that the figures given are not much different than those charged by many physicians in this country.

I investigated also the costs of certain surgical operations and learned that the charges for a tonsillectomy varied from $19.50 to $130.00 (300 to 2,000 soles). I did not inquire why there was such a wide variation here, but assumed that only the wealthy people would be charged the higher figure. My next inquiry concerned a major operation. I chose one of the most common, namely, removal of the appendix. There is apparently a wide spread here, which would be expected. The charges range from $32.50 to $325.00 (500 to 5,000 soles).

The cost for obstetrical service also interested me and I was told that the average charge was

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$325.00 (5,000 soles) for a delivery. This included a stay in the hospital for eight days, and presumably included also the ordinary nursing service.

Lastly, since there has been some controversy about the high cost of eye-glasses in this country, I inquired about the cost of an average pair of glasses in Peru. The figure given me was about $4.55 (70 soles). I was shown a couple of these and to me they appeared quite satisfactory. They probably were not as fancy as those commonly seen in this country, but they were serviceable and decent enough looking.

I did not carry my researches beyond this point – not that I was incurious, but I did not want to appear too prying. It should be emphasized that there are many poor people in Peru and the ills of many of these are taken care of in the free dispensaries. The charges I have given doubtless apply only to those who are in moderately comfortable economic circumstances.

HEALTH AND SANITATION

In many foreign lands, one must be careful what one eats and drinks. Peru is no exception in this regard. We were warned by some of our American friends, who lived in Peru, to be careful of the drinking water, uncooked vegetables and dairy products. Both drinking water and uncooked vegetables may be contaminated with organisms capable of producing dysentery, especially of the amebic type. It so happened during my visit there that strawberries were in season. It took more than a little will power to turn these down. Dairy products which, of course, include milk, butter, cream and ice cream were said to be unsafe not only because they might produce dysentery, but because of the prevalency of bovine tuberculosis in Peru. It appears that many of the dairy cattle are infected. The death rate in children due to tuberculosis is great. Apparently it would be too severe a strain on the economy of the state to do away with all the infected cows. To the new-comer this seems like a sad state of affairs, and surely demands attention of the Peruvian authorities. There is, indeed, much to be done to improve sanitary conditions in the entire country. As nearly as I could judge, the government is alive to these problems and is making an effort to solve them.

Finally, I cannot close my article without paying tribute to our Peruvian friends. We have much to learn from them – their friendliness, their hospitality, their innate courtesy, their charm of manner and their philosophy of life are virtues which we could well emulate. I, for one, indeed wish them well and hope that our relations with them will grow ever closer in the years which lie ahead.

"PHYSICIANS—WAKE UP!"

It is much later than it should be for the individual physician to realize, to have burned into his soul, as it were, that he is in reality two persons in one. He is first a physician entrusted with the care of these great United States.

One is as important as the other. If he neglects to exercise his functions as a citizen, here and now, he might, in the not distant future, wake up to find himself not only without rights as a citizen, but also, at the same time, a paid clerk of a bureaucratic government. His great profession, with its ideals and ethical standards, will be but a memory, and his position will be one without honor—without dignity.

A group of moral teenagers are endeavoring to entrap us by misinterpreting the maxim that "the common good has priority over the individual good." Their emotions are unbuttoned, and they have but a slight acquaintance with the commandment, "Thou shalt not bear false witness."

The physician as a citizen should fight for the right interpretation of the above maxim: That, in matters of health, he best serves the common good who has the liberty to advance and improve the present system of practice. No one knows as well as he what the common good is in this regard. No one knows better than himself the evils that would follow the regimentation of his beloved profession. He, himself, would be transformed from a physician into a filler of blanks, and his ability to devote himself wholeheartedly to his patients would come to a sudden stop.

Far above this, the patient would be an even greater loser.

The combating of this impending evil cannot be shifted by the physician to the A.M.A., or to his state or county society officials—although these should have his complete support and cooperation.

This is a personal problem of every physician in the United States. This is a patriotic duty. If he has never been in a fight before, he is in one now, whether he knows it or not, and it is a fight to the finish.

If he knows the enemy is advancing along a road that leads directly to everything near and dear to him, he should not ask any one to carry his rifle!

Physicians—wake up!—N. Y. St. J. Med.

EARLY IMMUNIZATION

To cure a disease is praiseworthy; to prevent it is a finer accomplishment. There is no longer any valid excuse for postponing immunization for pertussis. It can be instituted on the first day of life, if desired. Certainly it should not be delayed beyond the third or fourth month. Because of studies made and others in process more doctors are giving not only pertussis immunization but combined immunizations at earlier ages than the time-honored six months.—Evellynne G. Kmouf, M. D., in California Medicine.

THE RED CROSS IN 1949

The work of the Red Cross in West Virginia in 1949 is of interest to all of the people of our state, and especially to the nearly 150,000 persons who contributed $532,961 to the work of this splendid organization last year. The contributions were collected through the 62 chapters in the state.

Substantial contributions were made by the Red Cross during the past year to welfare and community activities, including disaster relief and rehabilitation, service to veterans and members of our armed forces, health programs and related services.

Assistance was given to 279 West Virginia families who needed help following disasters such as floods, fires, and wind and hail storms. A report concerning statewide activities was that this particular form of relief amounted to approximately $48,000, of which 84 per cent was spent for rehabilitation.

The program of services to veterans was carried out through local chapters and claims liaison representatives stationed at the VA administration office in Huntington and in the VA hospital at Huntington and Martinsburg. A total of 15,503 social cases were handled for veterans and their dependents through their local chapters. More than 12,000 claims cases in behalf of veterans and their families, as well as dependents of deceased veterans, were handled by the Red Cross liaison representative in Huntington.

Each month during 1949 local chapters in West Virginia sent an average of 247 volunteers to the VA hospital in Huntington and Martinsburg. More than 15,000 service men and their dependents in West Virginia received Red Cross assistance in 1949, a total of $90,913 being spent through home service workers to aid service men, veterans and their families. In the field of volunteer service, the backbone of the program of service to the community, a monthly average of 208 men and women gave 28,863 hours of their time during the year to the work of the Red Cross. These trained West Virginians served in many capacities, production workers alone completing a total of 8,686 articles requested by VA hospitals, Army and Navy camps, and institutions, and local and state institutions.

COLOR BLINDNESS

Color blindness may be congenital and is either total or partial. The former is very rare and is likely due to defective development or absence of cones. Partial color blindness is inherited through the female parent and is usually manifested by red-green confusion.—Fred D. Switzer, M. D., in J. Okla. St. Med. Assn.

SUPPLEMENT

A contributor to the *Journal of Pediatrics,* after a five month study of 59 convalescent children who received a seven ounce glass of milk an hour before each meal, concludes that the milk did not interfere with eating at mealtime but was an actual supplement for the diet.—Hygeia.

CAVEAT EMPTOR

In a laudable though sometimes overenthusiastic endeavor to synthesize and market new and better drugs for old and distressing illnesses the fact is sometimes lost sight of that, though effective, some of these drugs eventually prove harmful.

It seems definitely proved, for example, that folic acid will bring about a remission in pernicious anemia, but there is ample evidence that in some cases paralysis has followed the administration of the drug, and to the patient, it is quite unimportant whether the paralysis is caused directly by the drug or whether the tendency to neurologic involvement is simply enhanced. Benadryl, used to combat anaphylactic phenomena, may itself cause urticaria. Penicillin (an antibiotic followed by very few untoward eflects) may cause severe stomatitis when used in lozenges. The administration of aminopyrine—once thought to be a harmless analgesic—has been followed by death from agranulocytosis in many cases, its toxicity not having been demonstrated until nearly fifteen years after its introduction. The nitrogen mustards have unquestionably caused thrombocytopenia, leukopenia and anemia. The hemolytic staphylococcus has become penicillin-fast.

And now, in this issue of the *Journal,* comes a warning from one author that the very valuable drug quinidine may bring on thrombocytopenia of considerable severity and from others that Presidon, once considered harmless, may cause fatal agranulocytosis. The manufacturers immediately withdrew the prodct from the market, but it may still be on the dispensing doctors' shelves or in their bags.

The lesson that should be but seemingly has not been learned is that any new drug, however efficacious it may appear, mut be regarded as potentially dangerous until the contrary has been proved, and that this may take years; for more often than not the untoward symptoms are due to an individual idiosyncrasy of the patient to the drug rather than to a toxicity of the drug to all persons.—New England Journal of Medicine.

ALLERGY IN GENERAL PRACTICE

Allergy may be defined as a condition of unusual or exaggerated susceptibility to a substance which is harmless in similar amounts for the majority of members of the same species.

The word "allergy" was introduced in 1906 by von Pirquet to describe skin sensitivities seen in positive tuberculin tests. The word is derived from two Greek words meaning "other" and "energy" and was coined to connote "altered energy" or "altered re-activity" of tissue.

The subject of allergy has assumed such an increasing proportion in the field of medicine that every physician should be familiar with its principles. Allergy is important because it can produce symptoms in almost any part of the body. It therefore concerns both the specialist and the general practitioner alike.—Harold L. Nevenschwander, M. D., in Acuff Clinic Bulletin.

The President's Page

The fact that more than 25 per cent of the members of the West Virginia State Medical Association have already paid American Medical Association dues for 1950 would indicate that our doctors are completely in sympathy with this new procedure for raising funds to carry on the work of the parent organization.

Over 64 per cent of our members paid the voluntary AMA assessment in 1949. It is no secret that the effective work done in connection with the National Educational Campaign has contributed in no small way to an apparent change in attitude on the part of many of our representatives in Congress. While it is too early to count the day won, we do know that the forces behind the movement to socialize the medical profession have been at least temporarily stopped on the national legislative front. 1950 is a crucial year, and we cannot afford to rest on our laurels, expecting the opposition to remain silent.

I earnestly urge and beseech every member of the West Virginia State Medical Association to contact our two United States Senators and our six Congressmen. While letters are effective in a way, a personal interview with the Senators and Congressmen is most to be desired. Congress will no doubt adjourn by mid-summer, and letters written now and followed up by personal interviews later in the year will prove to be dominant factors in the attitude of these public servants on the question that now concerns medicine and allied professions.

Congressmen do pay attention to the letters received from their constituents. Being human, and in most cases desiring to be elected or re-elected, they will listen to a discussion of the issues before the country. It is certainly ethical and right and proper that medicine should seek to protect the gains that have been made under a system of free enterprise. Let none of us fail to continue this fight until the last threat of socialism has vanished.

Each candidate for Congress, no matter upon which ticket he is seeking nomination, owes it to his constituents to declare himself on important issues that he might have to face if successful at the general election in November. No candidate can afford not to make his position known on an issue so important as socialized medicine.

C. E. Watkins

President.

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PRE-MED STUDENTS IN WEST VIRGINIA

The enrollment of premedical students in Colleges and Universities is always of interest, for, from this reservoir come the future practitioners of medicine. Premedical education is an important function of any institution of higher learning. Those schools which train premedical students and have no affiliation with a College of Medicine are in a less favored position than those which do. This does not mean that many small colleges are not doing a good job in the training of premedical students. Indeed many of the smaller schools hold high educational standards and give excellent training.

In a large institution, counseling premedical students is practically a full-time job for one person. It is important that the counselor be familiar with the latest trends in medical education. If at all possible, it is desirable that the premedical adviser attend the faculty meetings of the Medical School. In point of fact there are some individuals who feel that it might be well for the Medical Schools to supervise premedical education which now is normally given in colleges of liberal arts. Be that as it may, a close liason between the Medical School and the premedical department is beneficial to all concerned.

As nearly as can be determined, there are well over 600 students registered in the premedical courses in the various schools in West Virginia. The institutions which have the most of the students are as follows: West Virginia University, 351; Marshall College, 90; Bethany College, 45; and West Virginia Wesleyan, 34. The remainder of the schools have less than 20 premedical students enrolled.

It is of interest to analyze the situation at West Virginia University somewhat further. Of the 351 premedical students registered there are 113 freshman, 86 sophomores, 86 juniors and 66 seniors. There are fewer seniors because most Medical Schools require only three years of collegiate work.

Besides the 351 premedical students at West Virginia University, there are enrolled 67 predental, 21 pre-nursing, 27 pre-medical technology, 1 pre-veterinary, 1 pre-osteopathy, 1 pre-occupational therapy, and 2 nursing education students. This makes a grand total of 474 students.

The total enrollment of the University for the first semester of 1949-50 was 6364 students. Therefore, 7.45 percent of them are interested in medicine and related fields. Previously the percentage was somewhat higher—between 9 and 10.

One explanation for this decrease in registration is that some of the students have learned that unless their grades were above the average it would be difficult to gain acceptance into an approved medical school, and consequently changed their course of study. It is possible, too, that some students who normally would register as premedical students did not do so because of the increasing difficulty of getting into a Medical School. Whatever the reason, there seems to be some indication that slightly fewer students are planning on making medicine their career. This is well, because due to the large number of applicants the pressure brought on the members of the Committee on Admissions and on Medical School administrators has been terrific during the past five years.

The parents of the students who are seeking admission into Medical Schools should not be judged too harshly. It is but natural for parents to feel that their children should have the opportunity to enter the field of their choice. The matter, however, is not as simple as that and probably never will be. Medical education is an enormously expensive undertaking both for the student and the school. Only those students should be admitted who give reasonable promise of having the ability, health and energy to carry successfully the work of the medical curriculum and withstand the exigencies of the practice of medicine, and still more important, give promise of being a credit in later years to the medical profession.

A BREAK FOR DIABETIC CHILDREN

Members of the West Virginia State Medical Association who treat children afflicted with diabetes have for some time been considering the establishment of a camp where the children may participate in every phase of camp life without foregoing continued necessary treatment. It remained for the new diabetes committee to take positive action, and we now know that West Virginia will have such a camp in 1950

It is obvious why diabetic children cannot attend the usual summer camps. Special problems involving diabetic routine and treatment preclude them from the usual activities throughout their childhood. Special camps most assuredly provide the answer to this important problem.

The action of the Carbide & Carbon Chemicals Corporation, of South Charleston, in donating the camp site and full equipment is certainly to be commended, and the doctors who are making the camp possible for these unfortunate children deserve the united support of the people of West Virginia.

We think that we can assure Dr. George P. Heffner, of Charleston, and the other members of the diabetes committee of the cooperation of the medical and allied professions in the establishment of this camp which will mean so much to diabetic children in this state.

MORE FAMILY DOCTORS NEEDED

The recent award of the American Medical Association's gold medal to Dr. Andy Hall of Mt. Vernon, Ill., has brought to light a career fairly typical of an old American institution, the family doctor.

Starting his medical career in a modest way, Dr. Hall had the usual struggle to get on his feet, and fought against the common obstacles of lack of equipment and poor transportation. As perhaps the most useful citizen of his community, his career is noteworthy chiefly because it is typical of the lives of countless general practitioners whose unselfish devotion to their calling has made them valuable members of society and has raised the general level of health to a high point.

The close personal touch of the old-style family physician gives him an intimate knowledge of his patients' physical and mental makeup. The psychological lift given the sick by the sight of the familiar, benevolent figure of their doctor has been more important than medicine to many a patient. The nation needs more family doctors.—The Charleston Gazette.

DR. McKAY'S WISE VIEWS

Under the headline we are using, the CHARLOTTE OBSERVER recently discussed editorially the ideas expressed by Dr. Hamilton W. McKay, president of the Southern Medical Association, who, to quote the editorial, has "outlined what might be termed a three-point program for the medical profession in its fight against the (Truman) administration's program.

> "First, he believes 'we must find a way for the physicians, the social scientists, the economists, and the government administrators to sit down together, to plan together, as they have failed thus far to do'.
>
> "Second, he believes 'we in the medical profession should be moving forward swiftly in our efforts to improve our own contribution to the advancement of those things in which we believe. Voluntary insurance plans must be made truly complete and broadly available. We must educate ourselves to a sense of real social responsibility'.
>
> "Third, he believes that, 'while we consider plans for the better organization of medical care, we should be devoting ourselves to the improvement of public understanding of the issues,' because, as he correctly says, 'in the final analysis, the decision will be made not by us but by the people of America'.
>
> "If the program Dr. McKay has outlined were adopted and fully carried out, the medical profession would have little reason to fear the decision of the American public."

Dr. McKay's views are unquestionably wise. The second and third points are attainable, but we have our doubts about the attainability of the first. Well do we remember when, upon one occasion at a meeting of the "Committee of Seven" with the Federal representatives in Washington, two of the representatives of organized medicine made earnest pleas for joining hands on the issue upon which there was general agreement and working together to attain these objectives, meanwhile deferring consideration of controversial matters until the points upon which there was unanimity of opinion had been translated into action. But a stony silence on the part of the government representatives ensued. We doubt seriously if bureaucrats will play ball when they cannot prescribe all the rules of the game. However, it might not do any harm to make another attempt.

There are so many things in the realm of health and medical service upon which there is essential unanimity of opinion as to what should be done to ameliorate conditions and insure progress that certainly a truly progressive program could be effectuated if all groups concerned would work together to put into effect

those points upon which there is general agreement. Maybe also, while tugging at the same end of the rope, we might learn to know each other better, to become more tolerant of each other's views, and, with the accomplishment of our first objectives and the passing of time, might learn that nothing very controversial or revolutionary is needed in our medical economy.

S. E. SURGICAL CONGRESS

West Virginia doctors are urged to attend the 18th annual session of the Southeastern Surgical Congress at Washington, March 6-9, 1950.

The presence of a large delegation from this state would be most fitting inasmuch as Dr. R. J. Wilkinson, of Huntington, a past president of the West Virginia State Medical Association, is president of the Congress. He is the first West Virginia doctor ever to hold this important office.

An interesting scientific program has been arranged, and those who attend the sessions will hear speakers outstanding in the field of surgery.

INDEED, WHY CHANGE?

The Bridgeport (Conn.) Post recently carried an editorial on the legislative situation in Washington which is so enlightening in character and so apropos that we pass on to our readers that part of it pertaining to the socialization of medicine:

"We would particularly call attention to Congressman (John Davis) Lodge's criticism of the Oscar Ewing free medical-service plan because we believe this is a matter which will come up for increasing attention in the near future and the public certainly needs to be informed about it. Said Congressman Lodge:

" 'He (the President) apparently favors the Oscar Ewing health plan which would deprive the American people of their choice of a doctor, lower the standards of the medical profession and generally encourage malingering'.

"If the experience of England is going to be any guide to us in the matter, that is exactly what would happen. There is probably no greater misuse of the English language than the attempt to call such plans free medical service. Every wage earner will pay for his medical services through pay-roll taxes, the difference being that while he still pays the bill he no longer has his choice of the doctor.

"This Nation now has the most expensive medical service and the widest hospitalization and the most free clinics of all kinds of any nation on earth, or historically, any nation past or present. Allowing for the sake of argument that one-eighth of the people do not get all the medical service which they might well use or that some of them do not get any at all (and we think that even this figure is exaggerated) the immediate effect of the Oscar Ewing plan would be to reduce the medical service now enjoyed by the other seven-eighths of the population.

"How much smarter it would be to improve our present system by extending it to the remote corners, the sparsely settled districts, or the mountain vastnesses where medical service is now scanty because of the sheer physical difficulty of rendering it. Why scrap the system which has produced the highest health standards in favor of something which we know, from the experience of other nations, will only give us something markedly inferior?

"Why we should turn to those nations whose standards are already inferior to our own and import their ideas to replace our more successful ones, is a mystery which can be explained in only one way, and that is, that a politician will resort to anything in order to create a glossy-looking issue."

THE RIGHT MACHINERY

We note that the State Medical Association has formed a 'grievance committee' to hear complaints of patients concerning members. Overcharging and complaints against professional services are mentioned as two of the most probable complaints to be heard by the grievance group.

The State Medical Association stoutly declares that the five-man committee will not be a 'mere gesture' or a 'sop' for patients complaints, but will function as a real committee, will make honest investigations and make recommendations in keeping with the findings of the group.

If such is actually the case, then the medical profession will have taken a real step forward in halting many complaints hurled in its direction during the past decade.

There is a current saying that if socialized medicine comes to America it will be the medical men who are responsible. In part, of course, the charge is true, but there are hard-working competent doctors plying their profession, thank God, and for them we, as well as the general public, have the utmost confidence and respect.

If the medical society's 'grievance committee' will act as a real factor in curbing some excesses engaged in by some members of the medical profession it will have made a real contribution to the medical men as well as the general public.

The average American does not want socialized medicine and won't have it unless it is forced upon him because he cannot obtain adequate services from private sources. What the medical profession needs is more 'country style' doctors and less specialists.—The Dominion News.

A DATE IN JULY

Although it is nearly five months until the West Virginia State Medical Association will convene for its annual meeting at White Sulphur

Springs, it is not too soon for members to be planning their annual visit at the Greenbrier.

Not at any other time during the year do our doctors have an opportunity in this state to hear so many eminent speakers on interesting scientific subjects than at an annual meeting. Certainly 1950 will prove to be no exception, for the program that has already been arranged is sufficiantly interesting to assure the success of the meeting.

No doctor who can possibly arrange to attend the sessions should fail to do so, for aside from the scientific value of the meeting, he will have the opportunity to renew friendships within the profession and visit and talk with other doctors whom he seldom sees from one meeting to another.

The attendance in 1949 could have been better, and as there is assurance that there is plenty of room for everybody, we hope that there will be a marked increase in attendance at the 1950 meeting at the Greenbrier, July 27-29.

GIVE TO YOUR RED CROSS

Dr. Elmer L. Henderson, of Louisville, Kentucky, president elect of the AMA, said recently that "by working with the American Red Cross during periods of emergency floods, tornadoes, fires, and other disasters, doctors know first hand the good that results from contributing to the Red Cross Fund."

This statement by Doctor Henderson can be subscribed to by any physician who has been called upon to give emergency medical care in any one of the hundreds of disasters that plague the country every year. It can be elaborated upon still further by doctors who give lifetime care to those who require it for many months or even years.

It is recognized that local physicians, dentists, nurses, and hospitals are responsible for the care of the sick and injured. They usually volunteer their services during the emergency period and sometimes extend it throughout the disaster operation to all patients who are Red Cross responsibilities. When necessary the chapter may provide reimbursement for the cost of medical and surgical supplies used in the treatment of all patients during the emergency period.

Following the emergency medical period, the chapter may remunerate physicians for professional services for disaster patients unable to meet their own medical expenses. Payment to physicians and nurses for the care of disaster sufferers for whom the Red Cross has assumed responsibility should be commensurate with local fees.

The American Medical Association and the American Red Cross have mutually agreed on major medical policies and practices applicable to disasters, and this understanding strengthens the valuable cooperation given by the medical profession over many years of disasters. A subcommittee on medical and nursing aid usually includes representatives of local medical societies.

March 1-31 are the dates for the annual Red Cross 1950 fund campaign, which has a goal of $67,000,000 to carry on all Red Cross services . . . Give to your Red Cross.

REJECTED SUITOR

Oscar R. Ewing, federal security administrator, appears to have misjudged the quality of his listeners in a speech made before the National Association of Retail Druggists on September 20. Mr. Ewing, apparently unmindful of the professional quality of the pharmacists' services, based his appeal for their support of compulsory health insurance almost entirely on the profit motive.

"Certainly," he reminded them at one point in his address, "any major progress we make in this age-old struggle against sickness and disease is sooner or later reflected in larger receipts for your own cash register." Again, in referring to the check-ups given last year to nearly two million children by public-health doctors or private physicians, he added, "And I don't doubt that most of the mothers wound up in the local drugstore with a doctor's prescription of one sort or another to be filled." And again, "Let me point out that the drug trade flourishes in the shadow of the hospital," and "If we can double the number of hospital beds available—as we intend to do over the next ten years—the effect upon your business will be literally enormous." Nor are these the only examples of the theme song of this particular oration.

Since the days when the apothecary was often the doctor and the doctor usually compounded his own prescriptions, up to the present, when the large-scale pharmaceutical manufacturer is a close ally in the progress of modern medicine, the reputable druggist has been an unselfish partner of the reputable physician in the care of the sick. Working long hours, frequently holding himself available day and night for emergency service, the responsible druggist rightly considers himself as something much more than a tradesman.

Subsequent to Mr. Ewing's speech a resolution was passed by the Association repudiating the federal political health scene.

Mr. Ewing, in his administration of the Federal Security Agency, has demonstrated his capacity for becoming a valuable and highly regarded public servant. There is little doubt that he is one of the able men of the present administration. The question can be raised, however, whether he is serving his country to his fullest capacity while he is almost obsessively preoccupied with the promotion of a plan to which the country is apparently not receptive.

GENERAL NEWS

PRESS-RADIO AND RURAL HEALTH CONFERENCES PLANNED FOR SPRING

Over 50 members of the West Virginia State Medical Association, including presidents, secretaries, treasurers and chairmen of public relations committees of component societies, attended the Secretaries—PR Conference held at Charleston, Sunday, January 29, 1950.

The Secretaries' Conference convened at 11:00 o'clock, and was devoted almost exclusively to administrative problems. Dr. Charles E. Watkins, president of the State Medical Association, delivered the address of welcome and presided at the morning session.

Dr. Thomas G. Reed, chairman of the Council, spoke on "Medical Education in West Virginia", and Dr. N. H. Dyer, state director of health, discussed "Problems of a Secretary of a Medical Licensing Board".

Dr. Donald R. Roberts, who for several years has served as secretary of the B-R-T Medical Society, presented a paper on "Problems of a Component Society Secretary", and the morning session closed with a roundtable discussion of administrative problems on a state as well as a county society level. This discussion was led by Charles Lively, executive secretary of the State Medical Association.

PR Conference

The afternoon conference followed a joint luncheon, and was under the direction of Dr. Frank J. Holroyd, chairman of the state public relations committee. A report on the work of state and county PR committees during 1949 was submitted by Doctor Holroyd, who then unfolded insofar as possible the program for 1950.

Doctor Holroyd reported that approximately 64 per cent of the members of the West Virginia State Medical Association had paid the 1949 AMA assessment, and that slightly more than 59 per cent, had paid the state voluntary contribution of $25.00 each. He further reported that West Virginia stands No. 29 on the list of the 53 constitutent associations in the payment of the 1949 AMA assessment.

It was further reported by Doctor Holroyd that West Virginia still stands number five on the list of state medical associations which have procured the adoption by state organizations of resolutions opposing compulsory health insurance.

Press-Radio Conference Scheduled

Announcement was made that a press-radio conference will be sponsored by the state PR committee, and that this conference will probably be held early in March. A third rural health conference, sponsored by the same group, will be held sometime during the spring.

The following doctors attended the joint conference:

T. Maxfield Barber, Charleston; James P. Baker, White Sulphur Springs; Robert C. Bock, Charleston; W. Carroll Boggs, Wheeling; F. M. Booth, Huntington; J. J. Brandabur, Huntington; O. T. Coffield, New Martinsville; Harry Coffman, Keyser; E. T. Drake, Williamson; N. H. Dyer, Charleston; Henry M. Escue, Charleston; Ray I. Frame, Madison;

S. William Goff, Parkersburg; James A. Heckman, Huntington; H. L. Hegner, Wellsburg; John P. Helmick, Fairmont; Frank J. Holroyd, Princeton; H. H. Howell, Madison; T. T. Huffman, Keyser; D. V. Kechele, Bluefield; James S. Klumpp, Huntington; L. Rush Lambert, Fairmont; Don H. Lough, Clarksburg; Athey R. Lutz, Parkersburg; R. V. Lynch, Clarksburg;

G. O. Martin, Martinsburg; John F. McCuskey, Clarksburg; Paul L. McCuskey, Parkersburg; Karl Myers, Philippi; J. L. Patterson, Logan; De Witt Peck, Montgomery; Curtis G. Power, Martinsburg; Maynard Pride, Morgantown; Thomas G. Reed, Charleston; W. Fred Richmond, Beckley; Donald R. Roberts, Elkins; William B. Rossman, Charleston;

C. M. Scott, Bluefield; Clark K. Sleeth, Morgantown; Theresa O. Snaith, Weston; R. D. Stout, Grafton; H. B. Strader, White Sulphur Springs; Walter E. Vest, Huntington; Paul E. Vaughn, Beckley; Paul P. Warden, Grafton; Charles E. Watkins, Oak Hill; E. J. Weller, Weirton; and L. D. Zinn, Clarksburg.

STATE DIABETES ASSOCIATION PLANNED

The ground-work for the formation of a West Virginia State Diabetes Association is being laid by the Diabetes Committee of the West Virginia State Medical Association. It is proposed to organize the association on a statewide basis. It will not be an amalgamation of local diabetes societies.

The purpose of the organization will be to promulgate and disseminate to its fullest extent diabetes education throughout the state. The association would sponsor open meetings with prominant doctors active in the fight against diabetes as the speakers for the purpose of impressing upon the laity the importance of the proper handling of the diabetes problem and full information concerning diabetes detection and, most important of all, dispelling fear of diabetes.

The proposed Association will be open to all members of the West Virginia State Medical Association, and the initial meeting will probably be held during the annual meeting at White Sulphur Springs, July 27-29. A skeleton constitution is now being prepared for presentation at this organization meeting, at which time it is proposed to elect officers for the following year.

The Diabetes Committee considers the organization of the new association its most important undertaking, and the cooperation of all doctors is being requested. Every doctor interested in, or treating diabetes, is requested to attend the meeting at White Sulphur Springs in July.

Doctors definitely interested in membership in the new association are requested to write to the Diabetes Committee, care West Virginia State Medical Association, Box 1031, Charleston. It is hoped that the nucleus of a large membership may be obtained prior to the organization meeting.

STATE BOARD OF HEALTH TO MEET

The regular spring meeting of the State Board of Health is scheduled for Charleston, March 16, 1950.

WEST VIRGINIANS HAVE PROMINENT PART IN RURAL HEALTH MEETING

Representatives from farm groups and organizations, the medical and nursing professions, hospitals, medical-hospital service plans, agricultural extension services. and public health groups met in Kansas City, Missouri, February 3-4 for the 5th National Conference on Rural Health. The attendance at this annual meeting which was sponsored by the American Medical Association was in excess of 350, and most of the representatives remained until the end of the conference on the afternoon of February 4.

A pre-conference meeting of chairmen of rural health committees from the various states was held February 2, and the theme for this meeting, "What Are We Doing About It?", brought answers from representatives from various parts of the country concerning programs projected for supplying adequate medical and hospital services for the rural people. All of the various sessions were under the direct supervision of Dr. F. S. Crockett, of Lafayette, Indiana, chairman of the AMA committee on rural health.

West Virginians on Program

Representatives from West Virginia played a very prominent part in all of the sessions. Miss Gertrude Humphrey, of Morgantown, state leader of home demonstration work, served as secretary of a discussion group which made a study of the relation of agricultural extension service to rural health problems. This group considered motivation of community effort together with a program of education through extension work. Miss Humphrey prepared the report of the combined groups which was submitted at the general session on the last day of the conference. She is a member of the advisory committee to the AMA committee on rural health.

Mrs. G. W. Myers, Jr., of Shepherdstown, president of the West Virginia Farm Women's Council, and Mrs. S. B. Wells, of New England, the treasurer, attended the conference, and the West Virginia Farm Bureau was represented by its secretary, Leland Booth, of Morgantown.

A former West Virginian, Mr. Paul A. Miller, instructor in the Department of Sociology at Michigan State College, East Lansing, had a very prominent part in the three-day program. He developed and supervised the work of the various groups studying the different problems with which the conference was concerned.

Mr. Miller is a native of New Cumberland, and received his B. S. degree at West Virginia University in 1939. He served as assistant county agent at Harrisville and afterwards as county agent for Nicholas county, with headquarters at Summersville. He has been at Michigan State since his release from the service at the end of World War II, and received his M. A. degree in rural sociology from that school.

Another native West Virginian, Dr. Roger Corbett, who was born in Morgantown, presented a general summary of all discussion groups at the morning session on February 4. Doctor Corbett is executive secretary of the American Farm Bureau Federation, and is also agricultural counsel for the National Association of Food Chains, with headquarters in Washington, D. C. He is a former assistant dean of the University of Maryland Agricultural College.

Dr. Harold C. Lueth, dean of the University of Nebraska School of Medicine, served as co-chairman of the group which studied methods of continuing education of physicians. Doctor Lueth was a guest speaker at the 1949 annual meeting of the West Virginia State Medical Association.

Rural Medical and Hospital Facilities

Reports were made concerning the building and maintenance of clinics and small hospitals in rural areas, funds raised locally being used for the most part instead of Hill-Burton funds. In many instances communities have raised part of the necessary funds and the balance needed has been contributed by one or more persons living in a particular community. It was brought out that some states use a mill tax or a sales tax to maintain hospitals after they are built. One of the "talking points" for construction of the hospitals in rural areas concerned the need for the availability of such facilities to the same extent as a fire department is needed in a small community. While the full bed capacity of these small hospitals might not be used at all times, such beds are available when a real emergency arises.

Many speakers stressed the fact that a community itself must make an effort to provide medical and hospital services, and the people must be willing to make this effort themselves in cooperation with the medical, nursing and hospital professions and the county and state health departments.

Another point brought out by representatives of farm groups was the fact that communities themselves must provide modern medical facilities if young doctors just finishing their internship are to be attracted to these areas. Reports were submitted showing that many small towns and rural communities have, through the combined efforts of rural groups and professional and business people, built and equipped offices for use by a doctor, and have provided satisfactory living quarters for him and his family. It all summed up to the need for a combined community plan to go all-out in an effort to improve a community by making available necessary medical, hospital, and nursing facilities.

Medical-Hospital Service Plans

The use of medical hospital and medical surgical plans to help pay for needed services was discussed by several speakers from communities where farm groups had been enrolled in the Blue Cross or other non-profit service plans.

Dr. Frank J. Elias, of Duluth, president of the Minnesota State Medical Association, reported that more than 50,000 farm families in his state are now insured under the Blue Cross and Blue Shield, and that already more than 80 per cent of the families in Duluth are covered by this type of insurance.

The problem of meeting the costs of medical care was discussed by several speakers and the hope ex-

pressed that the whole standard of living may be raised so that increasing numbers of people who live on our farms may be able to take advantage of prepayment insurance for medical and hospital care.

Health Nurses Needed

Some of the speakers placed emphasis upon the part county health nurses play in programs for improvement of community health, and one speaker expressed the opinion that it is more important to have a public health nurse to teach our people how to prevent disease and take care of themselves than it is to have a doctor in every community.

"Prairie Farmer" Editor States Needs

While rural communities may have to solve the problem of x-ray facilities and bed capacities in small clinics, the real need, it was pointed out, is for complete understanding on the part of farm people themselves of the importance of combined efforts to raise the standards of health in a given community. Dr. Paul C. Johnson, of Chicago, editor of The Prairie Farmer, expressed the opinion that "The time is ripe for a great health crusade in this country, and we share the conviction that that crusade should reach the rural people."

He quoted statistics to show that the farm population is growing smaller each year, thus creating additional problems of medical and hospital care. "One farm family," he said, "will generally supply the food to support ten city families. However, the migration is likely to continue from the country to the city. Our best available figures show that two out of five boys and girls born in the country migrate to the city."

Mr. Johnson stressed the need for speeding up the organization of community health groups. "More public health activities," he said, "means fewer people in the doctor's waiting room on Saturday afternoon. We need more county health departments run by rural people. We need more nurses, more doctors, and more inspectors appointed upon a non-political basis."

The mid-west editor of this popular farm paper believes that it is fine to put our efforts behind the plan for more hospitals, hospital beds, and doctors, but placed emphasis upon the importance of enlisting the interest first of the rural people and the need of selling them upon the idea of helping themselves.

Health a Purchasable Commodity

Dr. Lewis Webster Jones, president of the University of Arkansas, stressed the point that children are the most valuable crops that we raise on our farms. "We seem to be able to interest our people to a greater extent in the eradication and control of diseases of animals and plants," he said, "than in the improvement of the health of our farm children."

"It is a well-known fact," said Doctor Jones, "that health is a more or less purchasable commodity. It is necessary to make available to our farm population full information concerning the things that are now within their reach to help keep healthy."

Against Socialized Medicine

John Brandt, president of the National Milk Producers Federation, warned that "We should be careful that in our zeal to bring about better rural medical service we don't get into the position where we're going to permit some political crackpot to come and tell us what we have to do. Socialization of the medical profession would undoubtedly be the foundation for the socialization of all America."

Speaker after speaker from the great agricultural areas of the country made it very plain that they and the people they represent are completely, unalterably, and uncompromisingly opposed to socialized medicine.

Standards Should Not Be Lowered

Dr. Franklin D. Murphy, of Kansas City, Kansas, dean of the University of Kansas School of Medicine, deplored the insistence of some groups that the medical licensing boards revise their requirements for licensure by lowering standards to accommodate graduates of former class B schools, as well as graduates of unapproved foreign schools. "The tools of modern medicine," he said, "are too potentially dangerous to be put in the hands of the unskilled."

STATE HEALTH CONFERENCE MAY 4-5

The 26th Annual State Health Conference will be held at the McLure Hotel, in Wheeling, May 4-5, and the program is being arranged under the direction of Dr. A. Glenn Evans, director of the Marion County Health Department, who has been named chairman of the committee which will include chairmen of the various sections.

Topics to be discussed on the first day are "Health Protection For All," "The Local Board of Health, and "Selling Health to the Community."

On the second day papers will be presented on the following subjects: "The Community's Stake in the School Health Program," "Providing Public Health Training for West Virginians," and "Community Mental Health is Everybody's Job."

Section meetings will be held each afternoon on health administration, public health nursing, industrial hygiene, sanitation, public health education, human relations, and clerical and vital statistics.

The annual banquet is scheduled for Thursday evening, May 4.

CONTINUATION COURSE IN SURGERY

"Practical Problems in General Surgery" is the subject of a continuation course to be presented April 6-8 by the Frank E. Bunts Institute and the Cleveland Clinic.

On the evening of April 7, Dr. Daniel C. Elkin, of Emory University, Dr. Claude Beck of Western Reserve University School of Medicine, and Dr. R. B. Turnbull, of the Cleveland Clinic, will conduct a symposium on "Vascular Surgery."

On April 8, Dr. George G. Finney, of Johns Hopkins University, will be a member of a group which will present panel discussions on surgery of the colon, pancreas, biliary tract, and stomach and duodenum.

Information concerning the program and registration should be addressed to the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6, Ohio.

NATIONAL EDUCATION PROGRAM FOR 1950 OUTLINED AT CHICAGO MEETING

The all-day conference of public relations chairmen and executive secretaries of state medical societies and associations, sponsored by the American Medical Association and held in Chicago, February 12, was noteworthy in its practically unanimous endorsement of the plan of campaign that has been waged in opposition to compulsory health insurance.

The meeting marked to a day the first anniversary of the launching of the American Medical Association's National Education Campaign.

Two things were made clear as a result of the conference: First, the drive in congress for a welfare state has been slowed to a walk, and second, organized medicine will continue its efforts to expand voluntary medical and hospital service plans as its answer to those who seek the socialization of the profession.

It was brought out that organized medicine the country over is not only presenting a united front in the fight against what virtually amounts to a determination on the part of bureaucratic die-hards to foist socialized medicine upon the country, but is actually leading the fight in Washington.

Several speakers cautioned against any smug or complacent attitude but urged instead that those interested in keeping free enterprise alive attack the problem in congress with renewed vigor and faith in our rpresentatives to do the right thing and confidence that the battle will ultimately be won.

Profession United in Fight

Dr. Elmer L. Henderson, of Louisville, Kentucky, president elect of the AMA, was chairman of the meeting. In his opening remarks, he stated that the medical profession in America is more united than at any time during the more than one hundred years' existence of the AMA. He called for a free discussion of the problems that are being met and solved in every part of the country.

Dr. Ernest E. Irons, of Chicago, president of the AMA, a member of the panel which sat throughout the day, clarified the responsibilities of the profession in the national education campaign. "We have a great cause in which we can all unite in purpose and in action," he said, "and this cause is to save our country from socialism".

Strategy, Policies and 1950 Objectives

Leone Baxter, a member of Whitaker and Baxter, and general manager of the National Education Campaign, discussed 1950 objectives, outlining plans and procedures to be followed by the AMA and the state medical associations. "The first part of the campaign of the drive for socialism has been stopped at least temporarily," she said. "We must gain and hold the support of strong allies and convince them that the problem of medical care can be solved." Miss Baxter warned that medicine should be ready at roll call in congress for any socialistic legislation that might be proposed. "The extension of and improvement in voluntary health insurance plans constitute our prime objective," she said.

Commenting on the pressure that can be exerted by the administration in this fight, Miss Baxter said that "when the political might of the government itself is released to follow-up the reported statement by those in high office 'that we are going to defeat medicine', then medicine will realize that it has the fight of its life on its hands."

Miss Baxter reported that more than one thousand organizations not affiliated in any way with medicine have joined in the fight against socialism. She stated that these organizations have distributed to their members literally millions of pamphlets expressing opposition to socialized medicine.

Clem Whitaker, director of the National Education Campaign, in explaining strategy and policies, reported that proponents of compulsory health insurance are becoming wary and are no longer pressing for a roll call in congress. He urged that the campaign be vigorously prosecuted and expressed the hope that within the next few months there will not be a state where there is not a medical care program.

Medical School Enrollment Increases

Dr. Louis A. Bauer, of New York City, chairman of the AMA board of trustees, reported that although enrollment in medical schools is now more than ten per cent greater than before World War II, not nearly enough doctors are being graduated to meet the needs of our country. He further stated that the great need at the present time is for a better distribution of doctors. In New York City, the ratio is about one doctor to 400 people. He said that in the United States there is approximately one doctor to about 700 people (Ed: The ratio in West Virginia is one doctor in active practice to about 1,300 people).

Doctor Bauer reported that all of the medical schools are crowded, and that there is apparently no slackening in enrollment at any school.

Congressmen Hearing From Back Home

Dr. Joseph S. Lawrence, director of the Washington office of the AMA, in discussing pending legislation in congress, said that congressmen speak more freely and frequently of medicine than at any time in the past. Considerably more letters on pending medical bills are being received by the congressmen than ever before, and he urged that this close contact be maintained, urging conversations in person wherever possible.

Mrs. Paul Craig, of Reading, Pennsylvania, national PR chairman of the Woman's Auxiliary to the AMA, discussed the matter of Auxiliary cooperation in the National Education Campaign. She urged training for members of the Auxiliary to prepare them for public speaking and to educate them in specialty techniques and human relations, and urged that more interstate and intrastate regional conference be held with medical groups.

Mrs. Craig asked that time be taken by the leaders in medicine to work with the women and interpret

the Auxiliary's services to the general membership of the medical profession.

The part that the Ohio State Medical Association has played in the campaign to obtain full support for the National Education Campaign and the drive in congress opposing socialized medicine was discussed by Charles S. Nelson, of Columbus, the executive secretary. He presented an interesting and informative paper on techniques used in his state, and reported startling results obtained from a survey made after the last general election concerning percentages of members of professions voting.

Dr. James F. Norton, president of the New Jersey State Medical Society, was the last speaker at the afternoon session, and he discussed the progressive medical program that is in operation in his state.

The conference was attended by about 300 representatives from every section of the United States who were told at the conclusion of the formal program that the board of trustees had tentatively approved a national advertising campaign through the media of newspapers and the radio. No definite plans have been worked out, and, if held, the campaign will not be launched until late summer.

Dr. Frank J. Holroyd, of Princeton, chairman of the state PR committee, and Charles Lively, executive secretary, represented the West Virginia State Medical Association at the meeting.

WEST VIRGINIA DOCTORS AT AAGP MEETING

A large delegation of West Virginia doctors is attending the annual meeting of the American Academy of General Practice, which is being held in St. Louis as this issue of the Journal is on the press (February 20-23).

Dr. James C. Repass, of Lumberport, and Dr. Thomas H. Blake, of St. Albans, are delegates from West Virginia, and Drs. William P. Bradford, of Moundsville, and Halvard Wanger, of Shepherdstown, alternates.

Dr. J. L. Patterson, of Logan, is president of the West Virginia Academy of General Practice. Dr. Donald R. Roberts, of Elkins, is vice president, and Dr. Carl B. Hall, of Charleston, secretary-treasurer.

AMERICAN COLLEGE OF PHYSICIANS IN BOSTON

The annual meeting of the American College of physicians is scheduled for April 17-21, at Boston.

EASTERN PANHANDLE OVER THE TOP

Dr. George O. Martin, secretary-treasurer of the Eastern Panhandle Medical Society, reported a one hundred per cent payment of state dues on January 24, 1950, the first component society to go over the top.

Several societies are near the top, but as this issue of the Journal goes to press, Eastern Panhandle is the only society to report full payment of dues.

DR. R. J. WILKINSON TO PRESIDE AT S. E. SURGICAL SESSIONS

A large delegation of West Virginia doctors will attend the annual Postgraduate Assembly of the Southeastern Surgical Congress, which will be held at the Shoreham Hotel, in Washington, March 6-9, 1950. Indications are that the Assembly will have a record attendance from many states in the southeastern part of the United States.

Of particular interest to West Virginians is the fact that Dr. R. J. Wilkinson, of Huntington, is the president of the Congress, and will preside at the general sessions in Washington. His presidential address, "The Effect of Medical Education Upon Our Economic Future," will be presented on the evening of March 6.

Dr. Lucien A. LeDoux, of New Orleans, a past president of the Southern Medical Association, will deliver the C. Jeff Miller Lecture, his subject being, "C. Jeff Miller: His Teachings in the Management of Uterine Fibroids."

Dr. Elmer Hess, of Erie, Pennsylvania, will close the first night's meeting with a paper on "The Medical Profession and the Hospitals. Are Their Problems Resolvable?"

The following scientific program will be presented at the four-day meeting:

Monday, March 6

"Carcinoma of the Urinary Bladder."—Louis M. Orr, M. D., Orlando, Florida.

"Segmental Renal Functions Studies in Surgical Patients."—William L. Valk, M. D., Kansas City Kansas.

"Sigmoido-vesical Fistula; Diagnosis and Treatment." —Charles Stanley White, M. D., Washington, D. C.

"Nephropexy, Its Indications, Technique and End Results."—William F. Harper, M. D., Selma, Alabama.

"Familial Urological Diseases."—Albert E. Goldstein, M. D., Baltimore, Maryland.

"Chest Conditions Which Come Under Realm of General Surgery."—Archibald C. Hewes, M. D., Gulfport, Mississippi.

"Extrapleural Plombage Using Lucite Balls in the Treatment of Pulmonary Tuberculosis."—Otto C. Brantigan, M. D., Baltimore, Maryland.

"Clinical Significance of Intrapulmonary Neoplasms." —Edgar W. Davis, M. D., Washington, D. C.

"The Management of Carotid Body Tumors."—Raymond W. McNealy, M. D., Chicago, Illinois.

"The Complications of Spleenectomies."—J. D. Martin, Jr., M. D., Atlanta, Georgia.

"Radical Operation for Cancer of the Breast and Local Skin Recurrence."—William Crawford White, M. D., New York City.

Tuesday, March 7

"Surgical Treatment of Intra-Cranial Aneurysms." William F. Meacham, M. D., Nashville, Tennessee.

"Experiences in the Surgical Treatment of Congenital Pulmonary Stenosis."—Charles B. Olim, M. D., Memphis, Tennessee.

"The Use of Bone Bank Bone in Bone Surgery."—C. R. Rountree, M. D., Oklahoma City, Oklahoma.

"The Meckel's Diverticulum."—Hal E. Houston, M. D., Murray, Kentucky.

"Exploration of the Common Bile Duct."—Howard Mahorner, M. D., New Orleans, Louisiana.

"Diagnosis and Treatment of Carcinoma of the Larynx."—Gabriel Tucker, M. D., Philadelphia, Pennsylvania.

"Surgical Problems in the Aged Negro."—Willard H. Parsons, M. D., Vicksburg, Mississippi.

"The Treatment of Extensive Burns."—Hays R. Yandell, M. D., Tulsa, Oklahoma.

"Treatment of Mixed Peritonitis with Aureomycin."—George H. Yeager, M. D., William D. Lynn, M. D., and Thomas G. Barnes, Jr., M. D., all of Baltimore, Maryland.

"The Surgical Problems of: (1) Hypertrophy of the Female Breast. (2) Congenital Absence of Vagina."—Harry Lee Claud, M. D., Washington, D. C.

"Some Further Considerations in the Treatment of Surface Cancer."—Neal Owens, M. D., New Orleans, Louisiana.

"The Treatment of Squamous Celled Carcinoma of the Vulva."—Bayard Carter, M. D., Durham, North Carolina.

Wednesday, March 8

"The Management of Ectopic Pregnancy."—Frederick H. Falls, M. D., Chicago, Illinois.

"Carcinoma of the Cervix."—Enoch Callaway, M. D., LaGrange, Georgia.

"Uterine Bleeding, the Gynecologist's Bete Noire."—Gilbert F. Douglas, M. D., Birmingham, Alabama.

"Benign Lesions of the Cervix."—Conrad G. Collins, M. D., New Orleans, Louisiana.

"Surgical Aspects of Endometriosis."—Donald S. Daniel, M. D., Richmond, Virginia.

"The Conservative Treatment of Endometriosis in Young Women."—H. Hudnall Ware, Jr., M. D., Richmond, Virginia.

"Management of Hyperthyroidism."—Richard B. Cattrell, M. D., Boston, Massachusetts.

"The Spleen, a Few Surgical Aspects."—D. P. Hall, M. D., Louisville, Kentucky.

Thursday, March 9

"Gastric Resections and Vagotomies, Morbidity and Mortality in a General Hospital, not Associated with a Teaching Center."—Joseph S. Stewart, M. D., Miami, Florida.

"Gastrocolic Fistulae."—J. C. Patterson, Cuthbert, Georgia.

"Present Status of the Surgical Therapy of Gastric and Duodenal Ulcer."—Henry W. Mayo, Jr., M. D., Charleston, South Carolina.

"Recent Advances in the Treatment of Cancers of the Esophagus and Stomach."—George T. Pack, M. D., New York City.

"Haemangio-sarcoma of the Stomach."—Harry H. Kerr, M. D., and Ernest A. Gould, M. D., both of Washington, D. C.

"Colostomy and Ileostomy."—William C. Cantey, M. D., Columbia, South Carolina.

"Selection of Operation in the Surgical Treatment of Peptic Ulcers."—I. Ridgeway Trimble, M. D., Baltimore, Maryland.

The annual banquet will be held Tuesday evening, March 7, at 8 o'clock, and officers will be elected at a business meeting scheduled for Wednesday afternoon, March 8.

All sessions will be held at the Shoreham Hotel, and technical exhibits will be set up in the West Ballroom. Requests for hotel reservations should be made directly to the Shoreham Hotel, or to Dr. H. H. Schoenfeld, 1726 Eye Street, N. W., Washington, D. C.

STATE CAMP FOR DIABETIC CHILDREN ESTABLISHED BY DIABETES COMMITTEE

A camp for diabetic children, the first of its kind in West Virginia, is being established by the Diabetes Committee of the West Virginia State Medical Association. It will be open for one week, from August 26 to September 2.

The camp site and buildings and equipment have been donated for the purpose by Carbide & Carbon Chemicals Corporation, of South Charleston. The location is on Coal river, near Alum Creek, about 20 miles from Charleston. Equipment includes swimming pools, basketball and tennis courts, a football field, gymnasium, craft shop and hospital. Cabin facilities include running water, toilets, showers and electric lights.

Camp officers and personnel will include a full-time physician, a nurse, a technician, and camp directors and Councillors. A dietician will be responsible for planning all meals, and the children will be kept on well regulated diets and diabetic routines that will not interfere with their camp life. Information concerning diet and insulin requirements of children who attend the camp should be mailed to the Diabetes Committee in advance of the opening of the camp so that all details may be arranged ahead of time.

The Diabetes Committee reports that there will be no charge for diabetic children attending the camp, but parents who can do so will be urged to make such contributions as may be possible to the upkeep of the camp.

Children from 8 to 13 years of age will be accepted and the committee has requested the members of the State Medical Association to notify parents of diabetic children of the establishment of the camp and to supply the names of children who would like to attend. All correspondence should be addressed to the Diabetes Committee, West Virginia State Medical Association, Box 1031, Charleston.

The committee is composed of Dr. George P. Heffner, of Charleston, chairman; and Drs. O. D. Ballard, of Van; F. R. Whittlesey, of Morgantown; W. A. Thornhill, of Charleston; W. E. Bundy, Jr., of Oak Hill; and O. H. Brundage, of Parkersburg.

NEW HEAD FOR BUREAU OF TB CONTROL

Mr. Albert E. Rhudy, who has been serving as senior medical social worker at Pinecrest Sanitarium, in Beckley, since July, 1948, has been appointed by Dr. N. H. Dyer, state director of health, as acting director of the bureau of tuberculosis control of the state health department. He succeeds Dr. C. L. A. Wehr, who resigned in October, 1949, to accept a surgical residency at the White Cross Hospital, in Columbus, Ohio.

Mr. Harrison Koppe succeeds Mr. Rhudy as senior medical social worker at Pinecrest.

According to Doctor Dyer, a monthly average of approximately 350 patients and members of their families have made use of the service since it has been in effect for the purpose of meeting certain personal problems which otherwise might have caused interrupted treatment.

OPENINGS FOR DOCTORS REPORTED IN SEVERAL WEST VIRGINIA TOWNS

Requests for "relief doctors" for temporary and permanent work are received almost daily at the headquarters offices of the West Virginia State Medical Association. In the hope that it might be possible to find doctors interested in openings in essentially industrial and rural communities and small towns, a list of the communities in need of doctors will be published occasionally in the Journal.

According to information compiled during the past few months, there are openings for doctors in the following cities and towns in West Virginia:

Ameagle	Littleton
Auburn	Lost City
Belington	Lumberport
Berkley Springs	Lundale
Brandonville	McAlpin
Brooklyn	Morgantown
Bruceton Mills	Mullens
Cairo	Nellis
Cass	Omar
Circleville	Pennsboro
Clay	Quinwood
Cowen	Salem
East Gulf	Sharples
Ellenboro	Union
Fayetteville	Valley Point
Gary	West Union
Hundred	Whitesville
Keystone	Yeager
Layland	

The names of doctors, persons, or groups reporting openings in various West Virginia communities may be obtained by writing to the West Virginia State Medical Association, Box 1031, Charleston 24, West Virginia.

ORTHOPEDIC NURSING INSTITUTES PLANNED

The West Virginia State Nurses' Association has announced that four three-day institutes on nursing care of orthopedic patients have been scheduled during the month of April. Two of the institutes will be held April 3 and April 6, at St. Francis Hospital, in Charleston, and two at Fairmont General Hospital, in Fairmont, April 10 and April 13.

The institutes will be conducted by Miss Teresa Fallon, R. N., consultant for the National Joint Orthopedic Nursing Advisory Service. She will have an assistant, and demonstrations of correct techniques in orthopedic nursing care are planned.

Nursing arts instructors in schools of nursing and hospital orthopedic supervisors will be invited to attend the sessions, and a general invitation has been extended to interested members of the West Virginia State Medical Association to be present.

The institutes are being sponsored by the West Virginia State Nurses' Association, with nine health and welfare agencies which work with orthopedic patients cooperating.

FELLOWSHIPS IN PEDIATRICS AT TULANE

The Division of Graduate Medicine and the Department of Pediatrics at Tulane University School of Medicine, in New Orleans, are completing plans for continuous training fellowships in pediatrics designed particularly to meet the needs of general practitioners from rural communities who have a major interest in problems peculiar to diseases in infants and children.

Applicants should be under 45 years of age and should have been out of medical school for less than ten years. The course is planned particularly for doctors who are practicing in communities of less than ten thousand population. The course of study will continue over a period of not less than three months, and appointments will be made on the basis of merit and need. Application may be made by any qualified doctor, either directly or through a sponsoring agency.

Full information concerning the course may be obtained by writing the Director of Graduate Medicine, Tulane Medical School, 1430 Tulane Avenue, New Orleans, Louisiana.

DR. PAUL R. HAWLEY WITH ACS

Dr. Paul R. Hawley has resigned as chief executive officer of the Blue Cross and Blue Shield Commissions to accept a position as director of the American College of Surgeons. No successor has been appointed. He assumes his new duties March 1, 1950.

PG COURSE IN DISEASES OF THE CHEST

The Third Annual Postgraduate course in Diseases of the Chest, sponsored by the Pennsylvania Chapter of the American College of Chest Physicians together with the Laennec Society of Philadelphia, will be presented at the Warwick Hotel, in Philadelphia, April 10-14, 1950.

Recent developments in aspects of diagnosis and treatment of diseases of the chest will be emphasized and the course will be open to all physicians. The tuition is $50.00 and applications will be accepted in the order of which they are received. Applications should be mailed to the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

WVU SCHOOL OF MEDICINE TO SPONSOR TWO-DAY PUBLIC HEALTH CONFERENCE

The West Virginia University School of Medicine is sponsoring a two-day public health conference which will be held at Morgantown, March 31-April 1. The theme of the conference will be "Current Problems in Public Health as Applied to West Virginia," and the various speakers on the program will use the theme as it pertains to their particular field.

It is the desire of the sponsors to provide a program that will be of interest not only to all persons engaged in public health work, but also to those interested in the promotion of public health in West Virginia. The primary purpose of the meeting is to stimulate interest in the public health program of the state.

Papers will be presented at general sessions in the morning and afternoon of Friday, March 31, and on Saturday morning, April 1. Time will be provided at the close of each session for a general discussion of the subjects presented.

The speakers, who are leaders in their respective fields, will discuss topics such as sanitation, epidemiology, mental health, tuberculosis, nursing, and industrial hygiene.

Speaking assignments for the Friday and Saturday sessions have been accepted as follows:

R. J. Anderson, Chief, Tuberculosis Division, United States Public Health Service.

Mr. J. J. Bloomfield, Assistant Chief, Industrial Hygiene Division, United States Public Health Service.

N. H. Dyer, M. D., Director, State Department of Health.

W. McD. Hammon, M. D., Head of the Department of Epidemiology, School of Public Health, University of Pittsburgh.

W. Overholser, M. D., Superintendent, Saint Elizabeth's Hospital, and Professor of Psychiatry, George Washington University School of Medicine, Washington, D. C.

Miss Lucile Petry, Chief Nurse Officer, United States Public Health Service.

P. D. White, M. D., Professor of Medicine, Harvard University School of Medicine.

Dr. Leonard A. Scheele, surgeon general of the USPHS, will be the speaker at the banquet, which will be held on Friday evening, and Dr. Thomas Parran, former surgeon general of the USPHS, and now dean of the School of Public Health of the University of Pittsburgh, will be the speaker at the luncheon on Saturday.

The committee in charge of the conference is composed of Dr. John N. Slack, chairman, and Drs. E. J. Van Liere, Clark K. Sleeth, and E. H. Ludwig, all of the West Virginia University School of Medicine.

WASHINGTON AMA OFFICES MOVED

The American Medical Association has leased the entire building at 1523 L Street, N. W., for the use of its Washington office, of which Dr. Joseph S. Lawrence is the director. Rooms Nos. 300 to 312 will be used for the purpose. The headquarters offices were formerly located at 1302 Eighteenth Street, N. W.

RELOCATIONS

Dr. Milford F. Townsend, of Dailey, has moved to Petersburg where he will continue in general practice.

* * * *

Dr. Joseph T. Peters, of South Charleston, has accepted appointment as a member of the medical staff of the Carbide & Carbon Chemicals Corporation in that city. He assumed his new duties February 3, 1950.

* * * *

Dr. C. W. Vick, of Jenkinjones, who has been in active practice for nearly 50 years, has retired and moved to Bluefield. He has been engaged in industrial practice at Jenkinjones for the past 30 years.

ACAD. OPH. AND OTOL. TO MEET MAY 8-9

The third annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held at The Greenbrier, White Sulphur Springs, May 8-9, 1950. An interesting scientific program has been arranged for the two-day meeting.

MCV RECEIVES $400,000 BEQUEST

A bequest of $400,000, made by Mrs. Wilkins C. Williams, has been received by the Medical College of Virginia. According to Dr. W. T. Sanger, the president, the bequest will be used to establish the A. D. Williams Memorial Clinic Foundation as a memorial to Mrs. Williams' husband.

DR. FISHBEIN WITH PUBLISHING HOUSES

Dr. Morris Fihsbein, until recently editor of the Journal of the American Medical Association, has been named consulting medical editor for two Philadelphia publishing concerns, Doubleday & Company, Inc., and the Blakiston Company, medical and scientific publishing affiliate of the Doubleday Company.

SANITARY SURVEY IN McDOWELL

Mr. Robert S. Jacobson, engineer for the division of sanitary engineering of the state department of health, is making an intensive investigation of sanitation hazards in McDowell County.

According to Dr. N. H. Dyer, state director of health, the program, covering each community in the area, will include inspection of public water supplies, treatment of water and distribution inspection of methods of present waste disposal, and survey of the methods of refuse collection and disposal.

At the conclusion of the study, recommendations will be made to the proper officials for the elimination or correction of existing hazards to public health.

The McDowell study will continue for about six months, and it is planned to conduct similar studies in other communities in the state in an effort to correct conditions either through education or enforcement of regulations governing certain phases of sanitation.

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

OBITUARIES

WILLIAM PERRY BAKER, M. D.

Dr. William Perry Baker, 35, of Morgantown, died January 28, 1950, at the U. S. Naval Hospital, in St. Albans, New York, following an illness of several months' duration.

Doctor Baker was born in Morgantown and received his academic education at West Virginia University, graduating with the degree of A. B. in 1935, and the degree of B. S. in 1937. He received his M. D. degree from the Medical College of Virginia in 1939, and was licensed to practice in West Virginia in 1941.

During World War II, he served as a medical officer in the Coast Guard, and had practiced his specialty of EENT continuously at Morgantown since his release from the service.

He was a member of the Monongalia County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Besides his widow, the former Phyllis Kersey, of Richmond, Virginia, he is survived by two children William Perry, III and Jennifer Louise, and his parents, Mr. and Mrs. Ralph E. Baker, of Morgantown.

* * * *

ROBERT WANEE CHAMBERS, M. D.

Dr. Robert W. Chambers, 53, of Beckley, died of a brain tumor February 9, 1950, at his home in that city.

Doctor Chambers was born at Dameron, West Virginia, son of the late Joseph and Eva (Cook) Chambers. After completing his academic training at Marshall College, he enrolled at Jefferson Medical College, Philadelphia, from which he received his M. D. degree in 1925. He was licensed to practice in West Virginia in 1926, and was located at Amigo from 1926 to 1937.

After completing postgraduate work, he moved to Beckley in 1938, where he practiced his specialty of EENT until illness forced his retirement some months ago.

Doctor Chambers had been a member of the board of education of Raleigh County for 8 years, serving as president from 1945 to 1949. He was a member of the Raleigh County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Besides his wife, he is survived by two children, Robert W. Chambers, Jr. and Mrs. L. Herbert Smith, Jr., both of Beckley.

* * * *

JAMES WILLIAM HARTIGAN, M. D.

Dr. James William Hartigan, 86, of Morgantown, died at his home in that city, January 23, 1950. Death followed a paralytic stroke suffered a few days previously.

Doctor Hartigan was born in Lexington, Virginia, and graduated from West Virginia University. He received his M. D. degree at Bellevue Hospital Medical College in 1887, and was licensed to practice in West Virginia in 1888. He served as professor of biology at

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West Virginia University and began the practice of medicine at Morgantown in 1900.

Doctor Hartigan served as superintendent of Weston State Hospital in 1929-31, and served for a few months in 1941 as chief surgeon at the McKendree Emergency Hospital, in Fayette County.

During World War I he served as a captain in the Army Medical Corps, being attached to the 25th general hospital.

Doctor Hartigan served as a member of the House of Delegates from Monogalia County at the 1927-29-31 and the 1943-45-47 sessions of the Legislature.

* * * *

HARWOOD HUGO RITTER, M. D.

Dr. Harwood Hugo Ritter, 38, of Charleston, died at his home in that city January 29, 1950, following a heart attack.

Doctor Ritter was born at Elkins, son of Mr. and Mrs. Charles Ritter. He received his academic education at Davis and Elkins College and the University of Virginia, graduating from the latter institution in 1931 with a B. S. degree. He received his M. D. degree at the University of Virginia Department of Medicine, Charlottesville, in 1935 and was licensed to practice in West Virginia in 1938.

He had practiced his specialty of surgery in Charleston for the past eight years.

He was a member of Kanawha Medical Society, the West Virginia State Medical Association, and the American Medical Association, and was a fellow of the American College of Surgeons.

Besides his widow, he is survived by his mother and two daughters, Ruth Leona and Caren Lee, and two sons Harwood H., Jr., and Charles J., all of Charleston.

* * * *

JAMES THOMPSON, M. D.

Dr. James Thompson, 55, of Morgantown, died at a hospital in that city following an illness of several months' duration.

Doctor Thompson received his M. D. degree at the University of Cincinnati College of Medicine in 1919, and was licensed to practice in West Virginia the following year. He had engaged in the practice of his specialty of surgery at Morgantown for the past 22 years. He is survived by his wife, his mother, and two sons.

He was a member of his local medical society, the State Medical Association, and the American Medical Association.

* * * *

DAVE S. STEWART, M. D.

Dr. Dave S. Stewart, 105, of Creston, died February 2, 1950, at his home in that city, following a lengthy illness. He had remained in active practice 66 years before he retired at 90 years of age.

Doctor Stewart graduated from Louisville Medical College in 1884. He is survived by three sons and two daughters.

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BOOK REVIEWS

PHYSIOLOGY OF HEAT REGULATION AND THE SCIENCE OF CLOTHING—Edited by L. H. Newburgh, M. D., Professor of Clinical Investigation, the Medical School, University of Michigan. Pp. 457, with 78 figures and 46 tables. Philadelphia and London: W. B. Saunders Co. 1949. Price $7.50.

In the words of the editor, "this book attempts to describe the responses of the heat regulatory mechanism to the whole range of climatic conditions encountered on the earth's surface. It emphasizes the maximal capacity of the mechanism to preserve life under the most adverse conditions and establishes the limits of this capacity. It shows how far the rigors of unfavorable environments can be mitigated by scientifically designed protective coverings. However, it does not assume to have given final answers."

The following authorities are responsible for the twelve chapters and the appendix of the book: Adolph, Bazett, Belding, Day, Forbes, Fourt, Hardy, Harris, Herrington, Robinson, Siple, Spealman, Van Dilla, Wulsin and Yaglou.

The opening chapter is concerned with the adaptations of certain peoples outside the European cultural tradition in respect to the nature and magnitude of the climatic stress, and the resources available to meet it. The necessary measurements and the laws concerning the extremely complicated transfer of heat by way of radiation, conduction, convection and vaporization between man and his environment are then considered.

An hypothesis of heat regulation of the human body is outlined, the details of which are taken up by various authors to complete Part I of the book. Here are considered the mechanisms of body temperature regulation in general, in adjustments to heat and to cold, under different extremes, at rest and in exercise, and during acute as well as chronic exposure.

Part II, entitled "Clothing, a Thermal Barrier," is opened with a consideration of the physical properties of clothing fabrics. This is followed by reports of laboratory and field studies in which the function of clothing is assessed by its effect on various temperature adaptive physiologic responses to a variety of environments. The concluding chapter outlines the general principles of clothing design most suitable for each type of environment, with particular emphasis on military needs.

The field of investigation, of which this book is a progress report, is fraught with amazing complexity which is further complicated by the incompleteness of knowledge in its various aspects. For the novice, there is ample warning, particularly in certain chapters, against making judgments on fragmentary evidence or carrying generalizations from one environmental or physiologic condition to another.

The nature and state of the subject along with the different points of view of the authors has led to a

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book which not only contains much duplication of material but is also probably more complex than it would have been if only one person had written it. In this sense the field is properly represented, and so this work should be particularly useful to those engaged in research as well as an authoritative, if not particularly lucid, source to those wishing to add to their knowledge.—J. C. Stickney, Ph.D.

* * * *

THE EYE AND ITS DISEASES—By 92 International Authorities. Edited by Conrad Berens, M. D., F. A. C. S. Pp. 1902, with 436 figures, 8 in colors. New, Second Edition. Philadelphia and London: W. B. Saunders Co. 1949. Price $16.00.

This book is the second edtion of Beren's Book, the first edition having been published some thirteen years ago. The fact that these thirteen years have been fruitful ones for the science of ophthalmology is recognized by the author as well as the practitioner.

All of the newer drugs and procedures are discussed by the author with the able help of his contributors. The list of contributors is practically a directory of the outstanding ophthalmologists of the world today, each one contributing in the book on the particular subject in which he is a recognized authority by the profession today.

The text is complete from superstition to surgery, yet it is brief enough to make it a most practical handbook for ready reference for the busy practitioner. Reading in the book recalls at once the style of Osler and it is this familiar style that makes it so practical for rapid reference.

It is almost impossible to select a chapter that stands out above others since each has been edited by a master of the subject with whom we are all familiar. To discuss the subject matter in a review of the book would require a copy of that material, so well is the work concentrated.

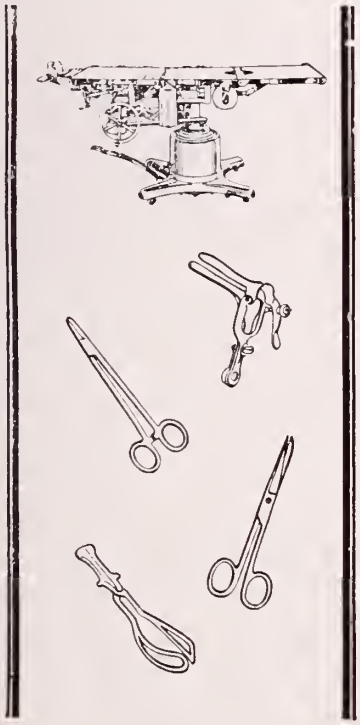
For the student with the desire for extensive reference on a given subject, the bibliography following each disease is most complete forming a cumulative index in minature of that disease as it has appeared in literature.

Beren's Textbook of Ophthalmology is a most practical book to study and pleasant to read.—Ralph S. McLaughlin, M.D.

* * * *

HANDBOOK OF DIGESTIVE DISEASES—By John L. Kantor, M. D., Gastroenterologist and Associate Roentgenologist, Montefiore Hospital, New York City, and Anthony M. Kasich, M. D., Lecturer in Medicine, Columbia University, New York City. Pp. 658, with illustrations. Second Edition. The C. V. Mosby Co., St. Louis, Mo. 1949. Price $11.00.

This successor to Kantor's "Synopsis of Digestive Diseases" is a well organized and very readable work. It is not a comprehensive treatise on the subject, but it does present the fundamental concepts of digestive disease from the standpoint of alteration of physiologic processes.



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The book goes into enough elementary detail to give the reader a sound footing without being tiresome, yet it does not neglect adequate coverage of the more specialized clinical aspects of gastroenterology. Concise descriptions of diagnostic procedures and clear discussion of therapeutic measures make this a manual which should be of great value to the general practitioner or the internist.—Clark K. Sleeth, M.D.

* * * *

HANDBOOK OF MEDICAL MANAGEMENT—By Milton Chatton, M. D., Instructor in Medicine, University of California Medical School, San Francisco; Sheldon Margen, M. D., Clinical Instructor in Medicine and Research Associate in Medicine, University of California Medical School; and Henry D. Brainerd, M. D., Assistant Clinical Professor of Medicine and Pediatrics, University of California Medical School. Pp. 476. First Edition. University Medical Publishers, Box 761, Palo Alto, California. 1949. Price $3.00.

This manual is divided into 20 chapters, each dealing with one broad group of diseases or one general type of medical management, and has a marginal index to facilitate location of chapters. The value of the subject material is somewhat limited by the disproportionate amount of discussion of symptomatic treatment. When specific treatment measures are dealt with, only the general principles are touched upon, leaving much detail for the reader to seek from other sources.

This pocket manual may have some value to the interne, or perhaps for the purpose of a quick review of principles. It suffers from the inherent defects of any such manual, especially that its use is likely to deteriorate into looking up the treatment for the symptom complained of.—Clark K. Sleeth, M.D.

* * * *

ESSENTIALS OF OBSTETRICAL AND GYNECOLOGICAL PATHOLOGY—By Robert L. Faulkner, M. D., Assistant Professor of Gynecology, Western Reserve Medical School, Cleveland, Ohio, and Marian Douglass, M. D., Formerly Assistant Professor of Gynecology, Western Reserve Medical School. Pp. 357, with 300 illustrations and three color plates. Second edition. The C. V. Mosby Company, St. Louis, Mo. 1949. Price $8.75.

In this book the authors have taken material freely from other standard texts on the subject, condensed much of this material, added some ideas of their own, and included several photographs. The book is written in a clear, readable style. Although no new important facts are brought out, a book of this type may have a definite appeal to some practitioners and especially to those who are interested in the fields of gynecology and obstetrics.—M. L. Hobbs, M.D.

* * * *

AN ATLAS OF AMPUTATIONS—By Donald B. Slocum, M. D., M. S., Orthopedic Surgeon, Sacred Heart General Hospital, Eugene, Oregon. Pp. 562, with 564 illustrations. The C. V. Mosby Company, St. Louis. 1949. Price $20.00.

The author of this book was formerly chief of the Amputation Section, Walter Reed General Hospital, Washington, D. C. He has written a very comprehensive account of the various types of amputations performed during the recent World War.

The book is well illustrated and goes into great detail regarding operative technique, the fitting of prostheses,

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and the teaching of amputees to use their artificial limbs.

The section on "Physical Medicine in the Treatment of Lower Extremity Amputations" was written by Donald L. Rose, M. D. In this, an excellent description is given of the various physical therapy modalities as applied to leg amputations. A number of composite photographs taken by Mr. Gjon Mili, showing the various types of gait used by amputees, is very instructive.

This book carries on the high level of amputation surgery established in the first World War, and described by Col. Kirk, later Surgeon General of the Army, in his book written following that war.— H. A. Swart, M.D.

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COUNTY SOCIETIES

BARBOUR-RANDOLPH-TUCKER

Dr. Milton S. Sacks, Assistant Professor of Medicine at the University of Maryland, Department of Clinical Pathology, was the guest speaker at the regular monthly dinner meeting of the Barbour-Randolph-Tucker Medical Society, held February 16, at the Tygart Valley Country Club. His subject was "Recent Advances in Hematology."

Dr. Charles E. Watkins, of Oak Hill, president of the West Virginia State Medical Association, was a guest at the meeting and spoke briefly concerning current medical problems.—Donald R. Roberts, Secretary.

* * * *

CABELL

Dr. Marion L. White, of Huntington, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society held January 12, in the Fireside room at the Hotel Frederick. He presented an interesting paper on "Bronchiectasis and its Surgical Treatment."

At the business meeting following the scientific program, Dr. B. B. Richmond, of Huntington, was accepted as a member by transfer from the Raleigh County

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Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 6, April 3, May 1.
Basic Principles in General Surgery, Two Weeks, starting April 3.
Personal Course in General Surgery, Two Weeks, starting April 17.
Surgery of Colon & Rectum, One Week, starting April 10, May 15.
Esophageal Surgery, One Week, starting June 5.
Breast & Thyroid Surgery, One Week, starting June 26.
Thoracic Surgery, One Week, starting June 12.
Gallbladder Surgery, Ten Hours, starting April 24.
Fractures & Traumatic Surgery, Two Weeks, starting March 20, June 12.
GYNECOLOGY—Intensive Course, Two Weeks, starting March 20, April 17.
Vaginal Approach to Pelvic Surgery, One Week, starting April 3.
OBSTETRICS—Intensive Course, Two Weeks, starting April 3, June 5.
PEDIATRICS—Intensive Course, Two Weeks, starting April 3.
Personal Course in Cerebral Palsy, Two Weeks, starting July 31.
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MEDICINE—Intensive General Course, Two Weeks, starting April 24.
Electocardiography & Heart Disease, Two Weeks, starting July 17.
Hematology, One Week, starting May 8.
Gastro-Enterology, Two Weeks, starting May 15.
Liver & Biliary Diseases, One Week, starting June 5.
Gastroscopy, Two Weeks, starting May 15, June 12.
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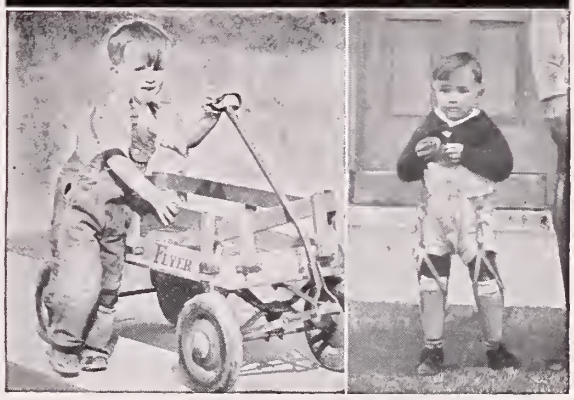

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Medical Society. Dr. Christopher J. Buscaglia, formerly of Huntington, but who is now located in Milwaukee, has affiliated with the Milwaukee County (Wisconsin) Medical Society.

Dr. James T. Spencer, of Charleston, presented an interesting and informative paper on "Diagnostic and Therapeutic Bronchoscopy" at the regular monthly dinner meeting of the Cabell County Medical Society held February 9, in the Fireside Room at the Hotel Frederick, in Huntington.

At the business meeting which followed the scientific program, Dr. Frank McDonald Peck, of Huntington, was elected a member of the Society. Dr. A. G. Rutherford, of Huntington, was elected to honorary lifetime membership in the Society.—James A. Heckman, M. D., Secretary.

* * * *

GREENBRIER

Dr. T. H. Smith, chief medical officer at the Federal Reformatory for Women, at Alderson, and Dr. Curtis G. Southard, psychiatric consultant and senior surgeon of the USPHS, were guest speakers at the regular monthly meeting of the Greenbrier Medical Society, held February 8 at the Alderson institution.

At the business session following the scientific program, Dr. George Lemon, of Lewisburg, was elected secretary-treasurer of the Society to succeed Dr. C. L. Houck, who has moved to Charleston.—James P. Baker, President.

* * * *

KANAWHA

Dr. J. Edwin Wood, Professor of Practice of Medicine at the University of Virginia, Charlottesville, was the guest speaker at the regular monthly dinner meeting of Kanawha County Medical Society, held December 13, at the Daniel Boone Hotel, in Charleston. His subject was "The Management of Acute Renal Insufficiency."

The annual dinner-dance on February 4, at the Daniel Boone Hotel, replaced the regular scientific

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program for January. Harry Geisel was the guest speaker at the dinner, and he presented an unusual and interesting address concerning the trials and tribulations of an American League umpire.

An emergency call system has been developed for Kanawha County as the result of demands of the Society for the expansion of medical services to take care of the needs of the people of the community. A poll of the members was made and the names of physicians who will participate in the program on a voluntary basis obtained. The system has been set up in connection with the local Physicians and Nurses' Bureau.—Robert C. Bock, M. D., Secretary.

* * * *

LOGAN

Dr. Charles E. Watkins, of Oak Hill, president of the West Virginia State Medical Association, and Charles Lively, executive secretary, were guest speakers at the regular monthly meeting of the Logan County Medical Society, held in the Auditorium at the Nurses' Home of the Logan General Hospital, January 11.

The speakers discussed pending national and state medical legislation, and the members of the society participated in the round-table discussion which followed.

The following resolution, offered by Dr. A. M. French, was unanimously adopted:

BE IT RESOLVED That the members of the Logan County Medical Society assembled approve the following objections to the creation of a grievance committee by the West Virginia State Medical Association:

The formation of a so-called "Gripe" Committee by the Council, to be composed of five past presidents of the State Medical Association, with final action to be taken by the House of Delegates at the next annual meeting, appears superfluous, unnecessary and undesirable for the following reasons:

1. American medicine is having enough trouble at the present time without the establishment of another facility inviting additional criticism by individuals or the public.
2. Adequate facilities already exist for the governing of the medical practice in this state, i.e., the public relations committees of the county medical societies, the county medical societies, district councilors, the council of the State Medical Association and the State Medical Association itself, and lastly but not least (and as you know, one of the most important) the Medical Licensing Board.
3. The incidence of complaints at the present time is relatively low but would increase many fold. In most instances, as now, the "gripes" would be of minor importance and unjustified.
4. Complaints of minor importance are best handled on a doctor-patient relationship rather than with a more formal set-up which among other things would magnify the situation.
5. The majority of complaints would be of minor significance; however, all of these necessarily would have to be considered and this would add an additional burden on the profession in that it would entail much correspondence, arguments, consummation of time and in the end little would be accomplished.
6. In many large areas in West Virginia there have been in existence for many years committees by various

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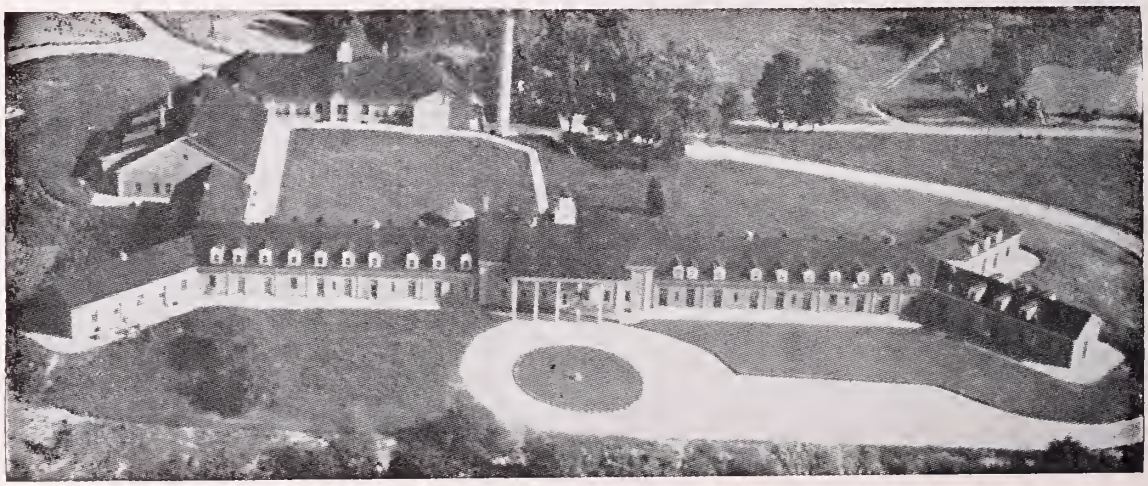

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names representing each local union, and which may be termed collectively "Gripe" Committees, which present to individual doctors and/or organizations concerned all kinds of complaints. The problems concerned are amicably solved in most instances without the aid of a centralized agency such as proposed.

7. Such a step suggests a continuation of (but not necessarily desirable) the centralization of authority which in some circles is so popular today.

8. The incidence of malpractice suits would probably increase.

9. Such a committee would be unfair to the profession in that "gripes" from the public are invited but complaints a doctor may have against a few of his patients would be without equal recourse. Again, in this respect the situation may best be handled on a doctor-patient basis.

10. As given in the press, one of the functions of the committee would be consideration of professional overcharge. Again, existing facilities are adequate and in one instance, at least, was satisfactorily disposed of So far the problem of fees is negotiated on a personal and individual basis and in the end any disagreement thereto not agreeably settled in the meantime would have to be on a civil legal action basis between the parties concerned. However, excessive fees are not condoned.

11. As inticipated, a State Grievance Committee would probably delegate most of this work to the respective county societies and again this would invite unnecessary controversy and trouble between the doctors and patients which is just the thing we have been trying to avoid.

12. Any reasons ascribed for the formation of such committee in opposition to socialized medicine do not appear valid since no connection appears obvious.

13. Component parts of the State Medical Association are already in existence to handle the moral and ethical conduct of its members.

14. The suggestion, apparently initiated by the American Medical Association and reportedly subscribed to by a few states, is no valid reason in particular for the formation of such a committee by any component of the American Medical Association.

15. Before the formation of a new committee inviting criticisms of the public, it appears more desirable to reactivate interest in the more or less dormant committees already established towards the elimination of discrepancies and irregularities existing within our own organization.

Dr. Walter E. Brewer, of Logan, the president, presided at the meeting which was attended by over 25 members of the Society.—Charles H. Hagan, Jr., M. D., Secretary.

* * * *

MERCER

The proposed Red Cross Blood Bank Program for Mercer County was presented by Dr. Hampton St. Clair at the regular monthly dinner meeting of the Mercer County Medical Society held January 30, at Pete's Grill in Bluefield. Following detailed discussion of the proposal, the matter was referred for study to a committee composed of Drs. L. J. Pace, Upshur Higginbotham, and E. L. Gage.

Dr. Upshur Higginbotham was elected delegate to the House of Delegates, and Dr. C. I. Butt, alternate.

Following the scientific program, Dr. Frank J. Holroyd reviewed John T. Flynn's book, "The Road Ahead." The review was discussed by several members of the Society.—Frank J. Holroyd, M. D., Secretary.

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MINGO

Dr. Charles A. Hoffman, of Huntington, was the guest speaker at the regular monthly meeting of the Mingo County Medical Society held January 11, at Welch. His subject was "Intravenous Urography." Following Doctor Hoffman's address, a Linde Air Products Company motion picture, "Physiology of Anoxia," was shown.

Arrangements have been completed to provide a weekly quarter-hour broadcast from local radio stations for the first 13 weeks of 1950. The program is being sponsored by the Mingo County Medical Society. The first of the series to be broadcast was titled, "Keeping Your Baby Well."—E. T. Drake, M. D., Secretary.

* * * *

PRESTON

At the January meeting of the Preston County Medical Society, the following officers were elected for the ensuing year: President, Dr. H. H. Cashman; vice president, Dr. D. R. Davis; and secretary-treasurer, Dr. C. Y. Moser (Reelected).

Dr. J. C. Arnett was named chairman of the public relations committee, and the Board of Censors will be composed of Drs. D. P. Brown, W. P. Johnson, and A. L. Starkey.

Dr. D. P. Davis was named chairman of the program committee, and the other members are Drs. H. C. Miller and C. E. Smith.—C. Y. Moser, Secretary-Treasurer.

WOMAN'S AUXILIARY

KANAWHA

Mrs. Paul H. Revercomb reviewed "The Golden Warrior," by Hope Muntz, at the regular monthly meeting of the Woman's Auxiliary to Kanawha Medical Society, held February 14, at the home of Mrs. Henry M. Glass, in Charleston. It was reported that this book was voted by the publishers as most deserving and least read in 1949.

At the business session preceding the entertainment program, it was announced that several benefit bridges would be held in various homes late in February, and that at the annual "Doctor's Day" program in April items of goods will be auctioned off and the proceeds used for the benefit of the nurses' recruitment scholarship fund.

It was agreed that the Auxiliary is to enter a table setting in a silver show to be held at Coyle and Richardson's Department Store, April 20-21. Mesdames R. H. Walker, Robert B. Price, and W. E. Hoffman will be in charge of the project.

Mrs. H. M. Hills, Jr., reported that over a thousand items of clothing have been collected and distributed to the department of public assistance for needy children, and Mrs. Newman H. Newhouse announced that she had secured 156 subscriptions to "Hygeia."

CHESTNUT LODGE ROCKVILLE, MARYLAND

In addition to its current psychotherapeutic program, Chestnut Lodge now offers facilities for the care, study, and treatment of the elderly patient requiring psychiatric supervision.

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Mrs. William A. Thornhill, the president, presided at the meeting, which was attended by 80 members.—Mrs. V. L. Peterson, Corresponding Secretary.

* * * *

MARION

Dr. Thomas Bess, of Keyser, chairman of the executive committee of the West Virginia Cancer Society, and past president of the West Virginia State Medical Association, and Mr. Charles Lively, of Charleston, executive secretary of the Association, were guest speakers at the regular monthly dinner meeting of the Woman's Auxiliary to the Marion County Medical Society, held January 31, at the Fairmont Hotel, in Fairmont.

The meeting was also attended by members of the Marion County Medical Society, and several guests.

Doctor Bess was presented by Dr. L. Rush Lambert, president of the Society, and Mr. Lively, by Mrs. Philip Johnson, Auxiliary legislative chairman.—Mrs. W. T. Lawson, Secretary.

* * * *

McDOWELL

At the January meeting of the Auxiliary to the McDowell County Medical Society, a program on the contents of "Hygeia" was arranged with a roundtable discussion on articles appearing in recent issues. Members present were asked to supply information on specific articles and discussions of the articles followed the reading of the card reports.

The McDowell Auxiliary is supplying milk and sandwiches for the crippled childrens' clinic. The food is served at the clinic by the members of the Auxiliary, who also lend assistance in various other ways.—Mrs. Ray E. Burger, Corresponding Secretary.

* * * *

MERCER

An interesting and enthusiastic meeting of the executive board of the Woman's Auxiliary to the Mercer County Medical Society was held late in January at the home of the president, Mrs. Frank J. Holroyd, of Princeton. Plans for the year were discussed by the various committee chairmen present, and it was agreed that the main Auxiliary project will be the participation of members in Dr. John W. Yost's pre-school clinics, arranged for one afternoon of each month.—Mrs. Fred S. Richmond, Publicity Chairman.

* * * *

RALEIGH

The regular monthly luncheon meeting of the Woman's Auxiliary to the Raleigh County Medical Society was held January 16 at the Beckley Hotel, in Beckley. Mrs. Ross P. Daniel, the president, presided during the meeting, which was attended by 35 members. Following the business session, tables of bridge were in play during the afternoon.—Mrs. Lucile A. Halloran, Secretary.

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955 Fourth Ave.
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Managing Editor and
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MR. CHARLES LIVELY
Box 1031
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Vol. XLVI APRIL, 1950 No. 4

MANAGEMENT OF OCCIPUT POSTERIOR POSITION*

By CHARLES L. GOODHAND, M. D., F. A. C. S.,
Parkersburg, West Virginia

Over a period of many years and probably for many years to come, the literature on the management of the occiput posterior position, has been and will be voluminous. This is because the problem is ever present, relatively frequent, and is always viewed with a certain degree of apprehension, as anyone practicing clinical obstetrics will agree. The morbidity, both maternal and fetal, and the mortality, particularly fetal, can be very high unless the management is given very careful consideration and follows certain time proven principles. This paper is based on 700 patients delivered by me in the past two and one-half years.

It is the concensus of opinion that all occiput posterior positions may be divided into three groups as far as management is concerned: 1. The largest group constituting about seventy to seventy-five percent of the total in which spontaneous rotation will occur after engagement and early in labor, with comparative ease in delivery, either spontaneously or with low forceps, as in anterior position. The chief objective is to make this group as large as possible by employing conservative measures in the handling of the entire group, and avoiding premature interferences. 2. There is a much smaller group, usually with some degree of cephalopelvic disproportion in some of which engagement does not occur until the second stage is reached, even after hours of labor and then fall into the first group or the third. Others in this second group do not become engaged after the second stage is reached, this being usually dependent upon the degree of disproportion present. These will have to be delivered by the abdominal route. 3. This group consists of those cases in which engagement occurs, but there is failure of rotation with a resulting persistent occiput posterior position. It is in this group that management varies somewhat, and it is in this group that I feel that a conservative policy pays rich dividends. Many feel that interference early in the second stage of labor in this group is the wise course to follow. Many others believe, and I subscribe to this latter, that one should wait for varying degrees of time in the second stage before interference, guided by the amount of progress being made, and the general condition of mother and fetus, thereby decreasing operative interference and lowering the station of the presenting part in the birth canal. The type of operative interference will be found to vary in different sections of the country, in different clinics, and with the skill of the operator in using some particular method.

CAUSATIVE FACTORS

Certain variations in pelvic architecture have been recognized as being of great importance in the occurrence of posterior position. Caldwell and Moloy have shown the high incidence of posterior position in the android pelvis by means of their x-ray studies, while Thoms has pointed out the occurrence in the transversely contracted pelvis. DeLee pointed out years ago the high

*Presented before the West Virginia Obstetrical and Gynecological Society at the meeting held in connection with the 82nd Annual Meeting of the West Virginia State Medical Association at White Sulphur Springs, August 6, 1949.

incidence of posterior position in a particular type of patient with a dystrophia dystocia syndrome, the short, stocky individual with girdle obesity that frequently spells trouble. The post-traumatic pelvis is also being seen more frequently. Other factors that must be considered in addition to pelvic asymmetry are mechanical ones such as fibroids, prolapsed small part, deficient muscle tone of uterus and abdominal wall.

INCIDENCE

There is a marked variation in the incidence of occiput posterior position in the various reports, depending upon the time and method of determination. Many of the patients enter the hospital in advanced labor, and examinations are usually abdominal and rectal, and the diagnosis may be easily missed.

In this series there were 97 cases determined either by x-ray early in labor or by vaginal examination in the later stages of labor. Of these, there were 36 cases of persistent posterior position or an incidence of 5.1 per cent. In addition, there were five patients in this series on whom cesarean section was done because of persistent nonengagement of the head, and the occiput in the posterior position. Of these cases there were 27 instances of right posterior, and nine instances of left posterior position. Doubtless there were many more patients in this series who began their labors as a posterior that rotated spontaneously to the anterior position fairly early in labor. Twenty-three of the patients were primigravida, and thirteen were multipara.

Of the 36 cases of persistent posterior occiput there were 16 cases that were delivered as a posterior either spontaneously or by low forceps. In the remaining 20 cases, seven of them were rotated manually to the anterior during the second stage and the patients allowed to continue in labor, being subsequently delivered by low or midforceps. Five were rotated manually, and delivered by forceps immediately following the rotation. Eight were rotated by forceps (Modified Scanzoni) because of inability to rotate manually, and delivered by forceps. The following points should be stressed: 1. Patients should be allowed to continue in second stage labor two hours or longer if progress is being made, and if the maternal condition and fetal condition are satisfactory. 2. Manual rotation is the procedure of choice when possible in rotating the fetal head because it is felt that the human hand will be likely to do far less damage to the birth canal than the obstetrical forceps, even in skilled hands. 3. Many patients can be delivered as a posterior without difficulty when the occiput reaches low pelvis as a posterior. Gentle traction by forceps at this stage will determine whether this can be easily accomplished, whether the head has a tendency to rotate as traction is applied, or whether the resistance is too great, thereby making rotation necessary.

OBSERVATIONS ON LABOR OF OCCIPUT POSTERIOR AND ITS MANAGEMENT

Calkins and Gustofson have done much to alleviate fear of the posterior position by showing that the position in itself should be regarded as a normal one, and labor so treated, provided that the condition of the mother and that of the baby remain good and that there is continued progress. It is the opinion of most observers that

TABLE 1. CASES OF PERSISTENT OCCIPUT POSTERIOR POSITION

No. of Deliveries	*Persistent Occipant Posterior Position*	*Right Posterior*	*Left Posterior*	*Primigravida*	*Multipara*
700	36 (5.1%)	27	9	23	13

TABLE 2. MANAGEMENT OF PERSISTENT OCCIPUT POSTERIOR IN THIS SERIES

Manual Rotation Followed by Forceps	*As a Posterior (Low Forceps or Spnt.)*	*Modified Scanzoni*
12	16	8

TABLE 3. CASES OF MANUAL ROTATION

Parity	*Manual Rotation Followed by Mid-forceps*	*Manual Rotation Followed by Low Forceps*
Primigravida	6	3
Multipara	2	1

labors should not be induced mechanically unless the pelvis is ample, the head engaged and the indication definite, because to do so is to invite serious trouble. The temptation to employ mechanical induction frequently is great, as many occiput posteriors may go at least two weeks past their expected date of delivery.

Labor is generally slower and longer in the persistent posterior postion, and the quality of the labor pains frequently is poor. The persistence of a rim of cervix frequently is seen because of the poor apposition of the head against the cervix. As a result it is not unusual to see the labor go beyond a twenty-four hour period, and of course this makes it imperative that measures be used to give rest and keep the patient in a good state of hydration. Rupture of the membranes is often early. The head stays high longer than in anterior position, and there is less flexion. The occiput may rotate to the hollow of the sacrum, or it may rotate to the anterior, or it may stop as a transverse arrest.

Diagnosis of disproportion is more difficult with the occiput posterior position, and unless the pelvis is highly contracted a trial of labor should be given. The pelvis should always be checked carefully, and full use made of roentgen pelvimetry. With an adequate pelvis the treatment is that of careful, watchful expectancy. It must be remembered that the station of the head is just as important as the degree of cervical dilitation, taking into account of course the necessity of not being fooled by the caput.

Occasionally the condition of the baby demands interference in the second stage of labor while the head is still above the spines in high pelvis. When this happens internal podalic version is safer than forceps. With the head at the spines or below, and the cervix fully dilated, manual rotation followed by forceps is the method of choice.

Patients with occiput posterior and with long labors must be kept in a good state of hydration both by oral fluids and by intravenous dextrose solution. Likewise, they must be given rest by the employment of various sedative agents in sufficient dosage to obtain the desired result. Many times we are agreeably surprised by the increased intensity of the labor pains following such rest periods with resulting satisfactory progress.

MORTALITY AND MORBIDITY

There was no maternal mortality in this series of 36 cases; there were no stillbirths; there were two neonatol fetal deaths within twenty-four hours following delivery. Both of these babies died as a result of intracranial hemorrhage. They were both in referred patients. One mother had an associated eclampsia with previous attempts at delivery; the second had had previous attempt at delivery with forceps. There were four patients who showed morbidity according to the standard of the American College of Surgeons. The use of penicillin and blood transfusions when indicated will definitely control morbidity in most instances.

SUMMARY AND CONCLUSIONS

1. Thirty-six cases of persistent occiput posterior in 700 consecutive deliveries are reported—an incidence of 5.1 per cent.

2. The vast majority of cases that begin labor as occiput posteriors will rotate spontaneously to the anterior, and deliver with comparative ease.

3. Cases of cephalopelvic disproportion with persistent non-engagement of the head should be delivered by cesarean section, preferably low cervical or extraperitoneal in potentially infected cases.

4. Persistent occiput posteriors should be allowed to continue in second stage labor for variable lengths of time depending upon the progress being made, and the condtion of mother and baby. A minimum of two hours should be allowed unless there is some contraindication.

5. Adequate rest for patients having long labor is imperative, as is also the maintenance of the proper state of hydration.

6. Manual rotation of the occiput to the anterior is the method of choice, if possible, followed by forceps when interference and rotation becomes necessary. Forceps rotation (Scanzoni, etc.) will probably be found necessary in a smaller number of cases.

7. A fair percentage of patients may be delivered as occiput posteriors with comparative ease and greater safety, especially in that group of patients in which the occiput reaches low pelvis as a posterior. A trial with low forceps will tell the story. An episiotomy, of course, is usually definitely indicated in all of these patients, but especially in the primigravida.

8. The number of cases of persistent posterior occiput will be held to a minimum if a reasonable duration of the second stage is strictly followed.

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LEUKEMIA

Leukemia remains one of the unsolved problems of hematology. The disease is characterized by unrestrained overgrowth of leucopoietic tissue and so belongs in the general group of malignancy. It seemingly arises from a generalized disturbance of leucocyte-forming organs rather than from a single cell characteristic of other malignancies such as carcinoma of the breast, stomach, uterus or prostate.

The incidence of leukemia is constantly upward. This is not due to greater diagnostic acumen in recognizing the disease but to an absolute increase in the number of cases. The death rate from leukemia tripled in the period 1920-1945. The Metropolitan Life Insurance Company found a 50 per cent increase in mortality in the five-year period 1941-1945 with leukemia accounting for 3.8 per cent of deaths from all types of malignancy in 1941-1945. Each year since 1940 more than 5,000 persons have died in the United States from leukemia.

There are many unexplained observations about leukemia. The disease is twice as frequent in males as in females; white persons are affected at a rate more than twice as great as non-whites; there is a definite geographic variation in incidence. A much higher death rate is observed on the Pacific coast than in the Southern states. This fact makes one think of varying exposure to some toxic agent such as exhaust gases from automobiles.—Russell L. Haden, M. D., in Virginia Medical Monthly.

EARLY VASCULAR DISEASE AND DIABETES

Regardless of whether early vascular trouble is a complication of diabetes, whether both diabetes and vascular disease represent some inherent tendency in a given patient, or whether the age of the patient at onset, the duration of the disease and the type of treatment have anything to do with the problem, the fact remains that apparently some diabetic patients are more prone to have vascular trouble at an earlier age than nondiabetic persons.

The diabetic person is an ideal paptient for the study of possibly early vascular disease and therefore commands the attention of all physicians interested in this problem.—W. Richard Ohler, M. D., in New England Journal of Medicine.

CALCINOSIS INTERSTITIALIS CIRCUMSCRIPTA

(Review and Case Report)

By MITCHELL S. MADISON, M. D.,*
Beords Fork, W. Va.

Calcinosis is a particular example of pathologic calcification in which multiple calcerous deposits occur in the skin, in the subcutaneous tissue, and in the deep seated interstitial connective tissue. It is essentially a chronic disease, relatively unnoticeable in its onset, and tending thereafter to be slowly, though not uniformly, progressive. The diagnosis can be easily overlooked or obscured by another disease. It is the intention of this report to review briefly the literature on the subject and to present a case which proved of diagnostic interest.

Weber[1] first reported a case of calcinosis in 1878 when he had a patient with subcutaneous calcerous deposits occurring in association with sclerodactylia. By 1934 Brooks[2] found 121 cases reported in the medical literature. Since then, more than 30 cases have found their way into medical journals. Reviews of the literature have been presented by Steinitz,[3] Weissenbach et al,[4] Rothstein and Welt,[5] Epstein,[6] Brooks,[2] Scholz[7] and Comroe et al.[8].

Calcinosis is classified into two types: calcinosis interstitialis circumscripta and calcinosis universalis.

1. Calcinosis interstitialis circumscripta has been called "callous gout," although it does not resemble the commoner uric acid gout. It is most often found in adult women, with deposits limited to the skin, subcutaneous and interstitial tissue of the upper extremities, especially in the fingers. Although the condition is chronic, it interferes little with the general health of the patient. In Steinitz's[3] series, the number of males to females was 1:6.

2. Calcinosis universalis consists of multiple deposits in the skin, subcutaneous and deeper interstitial connective tissue. It occurs more frequently in children and has a less favorable prognosis. In Steinitz's[3] series the sex ratio was equal.

ETIOLOGY

The etiology has been discussed by every writer on the subject and a number of hypotheses have been advanced, but as yet the etiology has not been established. Conditions suspected of having etiologic importance are cold, trauma, inadequate nutrition, endocrine abnormalities and renal disease. Barr and Thannhauser[9] viewed

*Now a Fellow in Surgery, Mayo Foundation, Rochester, Minnesota.

the disease as an expression of locally damaged tissue, especially when it occurs in the nutritional defects of Raynaud's disease or scleroderma. Thirty-eight of the 121 cases reviewed by Brooks[2] had associated scleroderma or sclerodactylia. In the remaining cases there was frequent coexistent Raynaud's disease, chilblains, acrocyanosis, or muscle fibrosis.

Hypervitaminosis D may enhance local deposition of calcium. Wilson's[10] case carried a high blood cholesterol which may well have been the source of a "poisoning with endogenous irradiated ergosterol."

Hyperparathyroidism can produce metastatic calcification. In clinical and experimental hyperparathyroidism, however, there results characteristically (a) a high blood calcium, (b) a low blood phosphorus and (c) an abnormally great excretion of calcium and phosphorus, findings which are utterly unlike any of those of the metabolic studies reported in calcinosis. In Medvei's[11] case the parathyroid tissue was reduced operatively, but without improvement. In calcinosis the blood calcium and phosphorus remain essentially normal.

PATHOLOGY

Histology reports are conflicting. Verse and Parkes-Weber[12] state that the earliest evidence is colloid swelling of the connective tissue, followed by deposition of calcerous granules in the fibrils of the connective and elastic tissues. In Wilens and Darby's[13] case the earliest deposits appeared in subcutaneous fat, within and between fat cells. Hunter, Morse and Moulonguet[14] reported cases in which calcification occurred in subcutaneous tissue following fat necrosis. Comroe et al[8] made a detailed study of the nodules and found them to contain a white "toothpaste-like" material. Microscopically, the nodules were composed of fibrous connective tissue containing, in places, foreign body giant cells surrounded by inflammatory cells. The larger areas were cystic and contained an inorganic matter, presumably calcium.

CHEMICAL ANALYSIS

Wells[15] and Brooks[2] agree that chemical composition of the concretions is approximately the same as that of bone: calcium phosphate 86 per cent, calcium carbonate 13 per cent, and magnesium phosphate 1 per cent. Traces of cholesterol have been present in rare instances.

CLINICAL MANIFESTATION

The disease usually begins in adult life with the patient characteristically giving a long history of diseases such as scleroderma or peripheral vasomotor diseases of varying severity approaching the full picture of Raynaud's disease.

The earliest symptom frequently is soreness or tenderness of a localized area of skin. Examination at such a stage reveals multiple discrete subcutaneous nodules, stone hard to palpation, differing greatly in size, and quite irregular in shape. The skin over the more superficial deposits sooner or later becomes red and inflamed, and ultimately breaks down with the formation of painful and usually shallow ulcers. A low grade secondary infection persists, and from time to time a chalky purulent discharge may take place from the calcerous deposits.

Distribution of the lesions is a characteristic of the disease, for the deposits seem especially to congregate in those areas where trauma is most likely to occur. Thus the limbs are the most commonly involved. Lesions around joints produce disability, but rarely pain. No calcification in the viscera has been found at autopsy.[2]

DIAGNOSIS

The diagnosis can be made from the following observations:

1. Superficial nodules, especially over the extremities.
2. X-ray studies reveal the nodules to be radiopaque.
3. The presenting symptom frequently is a sinus or ulcer discharging chalky material from a nodule.
4. Frequent coexistent Raynaud's disease, scleroderma, or other similar disease.
5. Histologic examination of a removed nodule reveals an inorganic substance in the midst of connective tissue frequently containing foreign body giant cells surrounded by inflammatory cells.
6. Chemical analysis of the concretions reveals a composition approximately the same as that of bone.
7. Normal blood chemistries usually are observed.

DIFFERENTIAL DIAGNOSIS

1. Forms of dystrophic calcification, for example, calcified lipomata, phleboliths and calcified tuberculous lymph nodules.
2. Forms of metastatic calcification such as have been reported occasionally to be associated with nephritis, multiple myeloma, leukemia, sarcoma, carcinoma, osteomyelitis and hyperparathyroidism.
3. Uric acid gout.
4. Myositis ossificans and myositis progressiva.

PROGNOSIS

When the onset occurs during adult life the disease rarely seriously impairs the general health. In circumscripta it seems to attain a certain level of severity and remain there. In severe generalized cases, especially in children, the prognosis is bad because of resultant disability and deformity with subsequent chronic ill health, muscular wasting and asthenia.

TREATMENT

Various types of treatment have been tried and, in a few cases, cures have been reported, while in an additional small number of cases improvement has occurred. In some instances, spontaneous cures were believed to have taken place. Kennedy[16] has reported a cure as the result of a ketogenic diet for three years. Bauer, Marble and Bennett[17] have demonstrated clinical improvement with the use of ammonium chloride. Craig and Lyall[18] reported a cure, and Brooks[2] reported an improvement with the use of disodium hydrogen phosphate (Na_2HPO_4). This compound decreases the intake of calcium by producing an alkaline intestinal tract. Hence the skelton competes for calcium and decalcification of the deposits is accomplished.

Most recent investigators favor the use of a diet with low calcium and low vitamin D content.

Symptomatic treatment probably is the most important: analgesics, local dressings and prevention of deformities. Curetting and excision of calcium deposits may be worth while.

CASE REPORT

A 60 year old married Jewish woman entered the Surgical Outpatient Department of Strong Memorial Hospital because of an intermittent discharge from her right 4th finger for 2 months.

Her history dated back twenty years, when she was first seen at the clinic. At that time she stated that her extremities had been cold and intermittently numb for the past 15 years, and she often had noted irregular white spots over her hands. The diagnosis of Raynaud's disease was confirmed by skin temperature studies and nerve blocks which revealed a considerable amount of arterial spasm.

Six months later she was admitted to the hospital for thrombophlebitis of the great saphenous vein. The phlebitis cleared and for the next 8 years she was followed in the various clinics for Raynaud's disease, pleurisy and rheumatoid arthritis.

Twelve years ago the distal phalanx of her right middle finger became painful and swollen. Two weeks later the skin on the finger tip broke, and a small amount of purulent material discharged. Examination in the Surgical Outpatient Department revealed the finger to be very tender, especially near the tip where the skin was sloughed, leaving a small but deep ulcer. No pus was expressed on gentle pressure. Clinical

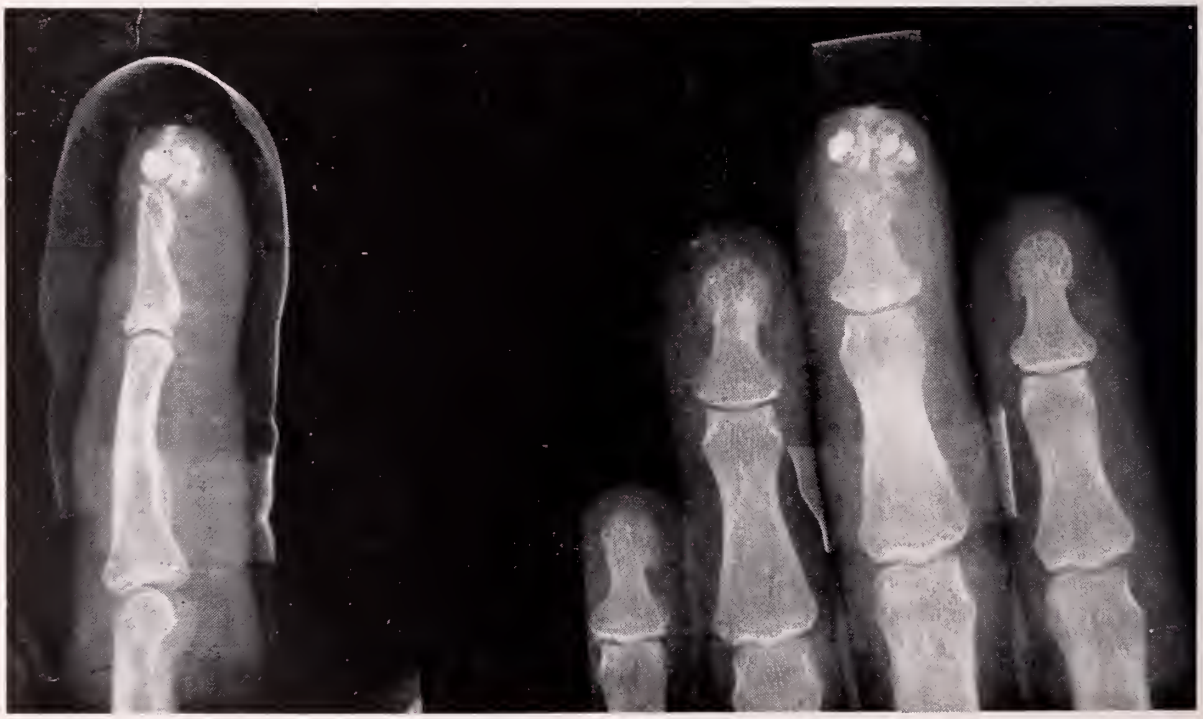

Fig. 1. (1935) Right hand. Concretions of distal phalanx of right middle finger with sinus tract.

Fig. 2 (1944) Right hand. Concretions seen in Fig. 1 have been removed. There is now a calcification near the middle phalanx of the 4th finger. This was not seen previously. In addition, small new densities are seen at the radial border of the second and third middle phalanges.

impression by the intern was a felon, and an x-ray was taken (figure 1). The wet film was interpreted as chronic osteomyelitis with sequestrum formation. The sequestrum was removed surgically. The official dry x-ray report came back as "concretions at distal phalanx of right middle finger with sinus tract".

For the next 4 years she was seen about every two weeks either in physiotherapy, the arthritic, vascular or medical clinics. Her complaints were mostly referable to arthritic pain in the left knee and coldness of the extremities. At one time she was given a course of x-ray to the cervical and sacral sympathetic ganglia to see if this would relieve the vasospasm, but no significant change resulted.

Eight years ago she noticed nodules over both elbows. A blood cholesterol taken at this time was 594 milligrams per hundred cubic centimeters. It was suggested that the nodules were cholesterol deposits, and that possibly the arthritic pain which the patient constantly complained of could be explained by cholesterol deposits in the joints. A low cholesterol diet reduced the blood cholesterol to 295 milligrams per hundred cubic centimeters but did not reduce the nodules nor relieve the arthritic pain. For the next 2 years the nodules increased in size, became painful, and the right one began to drain. Clinical impressions varied from cholesterol deposits, to xanthomata, to calcified sebaceous cysts. The nodules were removed and the pathology report read as follows: "Gross: A wedge of skin received with several pea-sized underlying nodules, many soft, some containing calcium. Microscopic: A layer of thin stratified squamous epithelium with regular rete pegs, underlying which are numerous hair follicles, hairs and sweat glands. About the numerous small vessels a few chronic inflammatory cells are located subcutaneously. Deeper down are two cyst-like structures composed mainly of calcium and rimmed by a dense fibrous investment. Diagnosis: Subcutaneous calcified nodules and chronic inflammation."

The microscopic description agrees with the findings of Comroe et al.[8]

The following year (5 years ago) the patient complained of pain in the left little finger where there was felt another hard yellowish subcu-

taneous nodule. The observer at that time noted that this nodule appeared to be similar to the ones that had been over the elbows. Blood chemistries showed calcium 9.8 milligrams per hundred cubic centimeters, phosphorus 3.5 milligrams per hundred cubic centimeters, uric acid 3.5, and cholesterol 258. The nodule was removed and the pathology report was the same as before (subcutaneous connective tissue with calcified nodules). The diagnosis was "acute and chronic inflammation."

Two years ago the patient complained of pain in her right hand. Examination showed the hand to be cold and blue, with several nodules palpable on the palmar aspect of the fingers. Repeat chemistries showed blood calcium 9.7, phosphorus 3.8, acid phosphatase 1.8 and alkaline phosphatase 4.2 King-Armstrong units. An x-ray of the hand (figure 2) read as follows: "Compared with the previous film (figure 1) calcification seen at that time at the tip of the right middle finger has been removed. There is now a dense, somewhat rounded calcification at the radial border of the middle phalanx of the fourth finger. This was not seen previously. In addition, small new densities are seen at the radial border of the second and third middle phalanges. The sesamoid bones of the distal interphalangeal joints of the thumb show increased density. Otherwise the bones of the hand appear normal for the age." It should be noted that the new concretion appeared between the taking of the two x-rays, a period of 9 years.

The patient was first seen by the author in April 1946 in the Surgical Outpatient Department, with the status and complaint as noted at the beginning of the case report. The finger was tender and edematous, with a firm nodule felt in the subcutaneous tissue. An x-ray (figure 3) was ordered, and on wet film the bone density appeared within normal limits, but at the base of the discharging sinus there was a bone-like opacity. Noting the diagnosis of chronic osteomyelitis with sequestrum formation 12 years ago, it was felt at first that the present picture was a result of the same condition.

The concretion was removed. However, not being satisfied by the diagnosis the dry films were

Fig. 3. (1946) PA and oblique of right hand. There is a small irregular calcification at the radial aspect of the head of the middle phalanx of the ring finger of the right hand. A much smaller one is seen in a similar position in the middle finger. Two small calcific densities are seen on the volar aspect of the interphalangeal joint of the thumb. These are thought to represent calcinosis interstitialis circumscripta.

checked, no evidence of chronic osteomyelitis being found. Likewise, the old x-rays were checked, with the same negative result. All the x-rays were reexamined, the radiologists[19] agreeing that the patient had never had osteomyelitis and that the impression noted 12 years ago on the chart was in error. The present impression was that the patient had calcinosis interstitialis circumscripta.

COMMENT

The history and findings in this case are typical of calcinosis interstitialis circumscripta: a long history of Raynaud's disease, the appearance of discrete subcutaneous nodules over the extremities on 5 different occasions, the nodules appearing radiopaque by x-ray, the presenting symptom on two occasions of a painful sinus discharging chalky material from a nodule, the histologic report of a removed nodule described as containing cyst-like structures composed mainly of calcium and rimmed by a dense fibrous investment, and the consistently normal blood calcium and phosphorus.

The characteristic presenting symptom first appeared 12 years ago and it is of interest to note that the condition was diagnosed as chronic osteomyelitis as a part of the patient's past history. When the nodules over the elbows were discovered 8 years ago, the blood cholesterol was high (594 milligrams per hundred cubic centimeters of blood). A low cholesterol diet lowered the level, but over a two year period the nodules increased in size. This corresponds to the findings of Wilson[10] in his case, in which there was a blood cholesterol of 480 milligrams per cubic centimeter of blood. Because of the elevated cholesterol, Wilson postulated that the calcinosis was due to an endogenous hypervitaminosis D superimposed on an old remitted Raynaud's disease. He tried all types of treatment: eliminatives, different acid base ratios, low protein, high protein, purine free diets and fat free diets, without improvement. Our case was not treated with eliminatives or diets other than a low cholesterol diet 8 years ago, because the patient refused hospitalization over a prolonged period of time in view of the rare number of cures. She found it impossible to carry out dependable home treatment.

SUMMARY

A typical case of calcinosis interstitialis circumscripta with associated Raynaud's disease is presented. The diagnostic difficulties are stressed. During a 12 year period the patient was seen by numerous observers, and various impressions recorded are chronic osteomyelitis with sequestrum formation, cholesterol deposits, xanthomata, calcified sebaceous cyst and felon. New appearances of calcium deposits in the right hand are recorded by x-rays. Except for an elevated blood cholesterol, the blood chemistries were normal.

A brief review of the literature is included.

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PILOT STUDY FOR HOME MEDICAL CARE

The aging of our population, the advances made in the early diagnosis of chronic disease, the increasing awareness on the part of the general population of the advantages of early and continued medical and hospital care, have brought us to the brink of a decision. We must face a future in which the demands made on our medical and hospital structure will be pyramiding upward at an ever-increasing rate even though our level of health continues to improve. To meet this responsibility, we must develop, in the form of pilot studies, areas of medical experimentation from which we can derive the formulas that will open for us the doors to better and more economical patient care.—Medical Annals, District of Columbia.

ACUTE ANTERIOR POLIOMYELITIS

By JAMES A. HECKMAN, M. D.,
Huntington, W. Va.

As in many other diseases, a great number of our basic concepts concerning poliomyelitis have changed in recent years as newer diagnostic and therapeutic methods have become available. The change is true particularly in the treatment of poliomyelitis. However, before considering the value of these newer methods of treatment, we should review the pathology and diagnosis.

PATHOLOGY

For many years students of medicine have been taught that anterior poliomyelitis is an acute infectious disease caused by a virus which invades the anterior horns of the spinal cord and eventually destroys the anterior horn cells thus creating a paralysis of the muscle groups innervated by those particular horn cells. The exact route or routes over which the virus travels to reach the spinal cord has never been ascertained although both the upper respiratory and gastrointestinal tracts have been incriminated as the primary sites of entry with either blood stream spread or an ascending infection along nerve fibers leading from these tracts to the central nervous system.

Certainly no one can deny the existence of an inflammatory process in the anterior horn cells with resulting necrosis as being the basic pathologic process, and certainly it has been conclusively shown that the etiologic agent is a virus. In the light of recent studies, however, it would appear that probably there are at least three and perhaps more viruses which are responsible for this disease.

To those who have treated large groups of patients in the acute stage it becomes apparent that the inflammatory process may involve the peripheral nerves and possibly the muscle themselves. It has even been suggested that the disease process ascends along the peripheral nerve fibers from the myoneural junction toward the central nervous system. This concept could account for the numerous cases which are seen in any epidemic where there is marked paralysis of one or more muscle groups on admisison to the hospital with complete or partial recovery in twenty-four to forty-eight hours.

It is also evident that the inflammatory process is not limited to the anterior horn portion of the spinal cord but that there is often diffuse brain involvement, as many cases of encephalitis as well as encephalomyelitis are seen during epidemics. In many such cases the virus of poliomyelitis has been recovered.

DIAGNOSIS

In considering the diagnosis of this disease it must be remembered that in any given epidemic as high as 80 per cent of all cases are of the abortive or nonparalytic type. Thus the manifestations of the disease run the gauntlet from a mild upper respiratory or gastrointestinal infection without evidence of paralysis to cases with massive muscle paralysis. Between these two extremes are the cases with mild muscle weakness, muscle spasm, symptoms of encephalitis, and bulbar involvement. In addition to the history and physical findings, examination of the spinal fluid is an aid in the diagnosis. The cell count in the fluid varies from normal to as high as two or three thousand. Contrary to popular belief the increase of white cells in the spinal fluid is not necessarily in the lymphocytic type but often in the polymorphonuclear type. Personal observation has led me to look upon this preponderance of polymorphonuclear cells as a serious prognostic sign as in many of these patients severe and often permanent paralysis develops. In addition, there is often a slight elevation of the protein content of the spinal fluid.

At Monmouth Memorial Hospital in Long Branch, New Jersey, the electromyograph is used as an aid in the diagnosis of poliomyelitis. The electromyograph is merely a machine which allows us to visualize the electrophysiologic processes involved in skeletal muscle action. The electric impulses are picked up by electrodes taped to the skin and visualized on the screen of a cathode ray tube after being intensified by a prestage amplifier. The waves visualized on the screen are photographed and thus a permanent record is obtained.

Ransohoff feels that in acute anterior poliomyelitis the following pattern of electrophysiopathology is seen:

1. Presence of resting action currents.
2. Presence of a pathologic stretch reflex.
3. Presence of disocdered reciprocal innervation (an upset of Sherrington's law).

It must be emphasized that the electromyograph is a laboratory instrument and as such should be considered only as an aid to diagnosis which must include the history, physical examination and examination of the spinal fluid; however, I believe its importance was best expressed by Dr. Frederick Thompson of New

Presented before the Staff, St. Mary's Hospital, Huntington, W. Va., Oct. 27, 1949.

York in discussing one of Ransohoff's papers when he said, "I believe it to be a very valuable instrument in the care of poliomyelitis from both the clinical and the physiotherapeutic standpoint. It is a machine which is a very sensitive index of the electrical potential present in the muscle. It is infinitely more sensitive than the cleverest examining hand. It has many values." And, "Above all, it is not too complicated for technicians or even doctors to learn and even operate. I believe that aside from its use in other spastic diseases, its value in poliomyelitis alone probably will make it a necessary standard equipment in most orthopedic hospitals."

TREATMENT

It is in the consideration of the modern treatment of poliomyelitis that we encounter a real variance in opinion and methods.

Prior to the migration of Sister Kenny to this country from Australia in 1940, there was a universal agreement among internists, pediatricians and orthopedists regarding therapy. The usual routine was for the patient to be placed in bed with all involved regions rigidly splinted in casts or other forms of immobilization in an attempt to prevent deformities during the acute and convalescent stages. Prolonged periods of bed rest were the usual routine extending in many instances up to many weeks and sometimes months. During the acute stage the symptomatic therapy was managed by the internist or pediatrician with the orthopedist looking after the splinted and immobilized areas. It was the considered opinion of all (and unfortunately in many areas still is) that any motion of involved muscle groups would fatigue the muscles and be detrimental. The end result in many cases treated thus has been unsatisfactory and eventually there has been need for many reconstructive procedures to correct deformities which were supposed to be prevented by the prolonged immobilization.

Although we may not be in agreement with Kenny's concepts regarding the physiopathology of poliomyelitis, although we may not accept her figures regarding the results of Kenny treated patients and in spite of her long fued with organized American Medicine, we must admit that without doubt she has made at least one outstanding contribution to the modern treatment of this disease, namely, proof that the institution of early motion with supervised physiotherapy is not detrimental but of definite benefit. Kenny believes that the use of hot packs during the acute, painful stages of the disease will relieve muscle spasm. There are many who disagree, but certainly the patients so treated are relieved of some pain. The nursing problem in the employment of hot packs is a great obstacle to surmount, and during epidemics many trained workers are necessary. Following the relief of pain, the Kenny system employs early muscle training and re-education under the guidance of specially trained physiotherapists. Certainly many of these patients have done well, although many have not. At least, all have been spared the prolonged periods of immobilization.

During the past four years at the Monmouth Memorial Hospital a system of therapy has been evolved by Ransohoff and his co-workers which utilizes the relaxing effect of curare and intensive physical therapy from the onset of the disease. The concepts on which this method of treatment is based are:

1. A muscle which has lost its normal length (a short muscle) is a weak muscle. Deformities result because of short muscles.
2. Long continued spasm will cause a muscle to become shortened.
3. Sherrington's law of reciprocal innervation must be in effect for normal muscle action.

As soon as a patient is admitted to Monmouth Memorial Hospital and the diagnosis of acute anterior poliomyelitis has been made, the patient is placed on curare (the preparation used in Squibbs Intocostrin), and the initial dosage is 0.9 units per kilogram of body weight every eight hours for the first twenty-four hours. If no untoward effects are noticed the dosage is increased to 1.5 units per kilogram every eight hours. It is administered by intramuscular injection. Physical therapy is instituted thirty minutes after the first injection of curare. Each joint is put through a full range of motion or as nearly a full range as possible until resistance is encountered. Then with gradual pumping motions that range of motion is increased. There must never be residual pain after stretching as this represents torn muscle fibers or hemorrhage into muscles. The physiotherapy is repeated after each daytime dosage of curare. The patients are taught to stretch themselves and one another. In addition to stretching, active exercises are started immediately. Bed rest is discouraged except for febrile patients.

The physical therapy methods are designed to re-establish normal muscle lengths and normal muscle physiology. It is freely admitted that the method of therapy has no effect on central nervous system pathology. The curare has no effect on the disease process but is merely an

agent to bring about muscle relaxation so that the physiotherapy may be instituted. Curare without physiotherapy is useless.

Since completing a residency at the Monmouth Memorial Hospital and coming to Huntington a little over fifteen months ago, the author has been able to continue his interest in this disease while supervising the treatment of a few patients at the Morris Memorial Hospital, Milton West Virginia. It was with a great deal of anxiety and caution that we attempted to utilize curare and intensive physiotherapy during the late summer and fall of 1948 as we realized that innovations in therapy often are not viewed too kindly by older and more experienced staff men. We found at Morris Memorial Hospital a combination of Kenny methods with the old orthodox measures. Most patients were receiving hot packs and many were being rigidly splinted. Most were kept at prolonged bed rest. During this period in 1948 we treated fourteen patients. Our routine was the use of intocostrin in somewhat smaller doses than advised by Ransohoff, immediate institution of intensive physiotherapy, early ambulation, the use of a Kenny bed, intensive occupational therapy, no casts, a minimum of splints and the encouragement of muscle substitution. Fortunately, we had no severe paralytics in this group. No deformities developed. One child with severe right lower extremity involvement has recovered to the point where she now walks with only a slight limp in spite of continued weakness in nearly all muscle groups in the involved leg. One child with marked deltoid weakness can abduct the arm to the pivotable position with only a trained observer being able to detect that she accomplishes this action by muscle substitution.

During this past epidemic we have treated twenty-six patients utilizing the same routine. To date there are no deformities although we are well aware that it is much too early to evaluate the results in either the 1948 or 1949 groups. We are certain of the following:

1. No patients have been harmed by this therapy.
2. Many patients have been discharged to their homes with no residual effects of their illness many weeks earlier than would be possible under any other known routine of therapy.
3. All patients are happier and more comfortable than patients treated by other methods.

It is interesting to note that the enthusiasm of the residents at Morris Memorial Hospital for this mode of therapy has led to the use of curare almost routinely on all services with the discontinuance of hot packs entirely. However, most of the other attending men are more conservative in early ambulation and continue to use splints to a greater or lesser degree. Intensive physiotherapy is used early on all patients.

It is to be re-emphasized that no claims are made that this mode of therapy in any manner affects the disease process or lessens the possibility of residual paralysis. We do feel that it is a rational approach to the treatment of acute poliomyelitis, that it simplifies the nursing care, and does prevent deformities from developing which are the result of shortened nonparalytic muscle groups.

SUMMARY

An attempt has been made to outline briefly the modern concepts of the pathology and diagnosis of acute anterior poliomyelitis, including a brief description of the electromyograph. The prevailing methods of treatment during the acute and convalescent stages have been discussed, and the method described by Ransohoff has been outlined. We feel that this method is a rational approach to the disease and offers the patient the best chance of recovery of any method now known.

Nothing has been said of reconstructive therapy in the late stage of the disease.

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DIABETES DETECTION DRIVES

Sponsored by the American Diabetes Association and the United States Public Health Service and other interested professional and lay groups, a campaign to discover the cases of unknown diabetes is underway.

All observers agree that the discovery of hitherto unsuspected diabetes is of tremendous importance. The nature of diabetes is such that if untreated the mild case frequently changes to the severe type. As a matter of fact, the physician has his best opportunity to do a real, constructive job in the intelligent management and careful follow-up study of the patient with mild diabetes. In no case should the finding of even a trace of sugar in the urine be disregarded.—W. Richard Ohler, M. D., in New England Journal of Medicine.

PRINCIPLES GUIDING THE UMWA WELFARE AND RETIREMENT FUND: MEDICAL, HEALTH AND HOSPITAL SECTION

By JOHN T. MORRISON, M. D.,
Area Medical Administrator, Charleston, W. Va., and
HAROLD MAYERS,
Hospital Consultant, UMWA, Washington, D. C.

We are presenting this discussion of some of the general principles which have guided the United Mine Workers Welfare and Retirement Fund, Medical, Health and Hospital Section in two rather inseparable parts. The first part refers to general principles of the hospital program itself while the second refers to the general principles guiding our relationship with health agencies of the community, doctors, nurses and hospitals, particularly as they have developed in West Virginia. We must state that while all principles planned have stood the test, the statement thereof has evolved more clearly as we have gained experience.

At the very outset, however, we must state our position at the present time before proceeding. On September 17, 1949, our participating hospitals, physicians and dentists were notified by Dr. Warren F. Draper, Executive Medical Officer of the United Mine Workers Welfare and Retirement Fund by a circular letter as follows:

"I have to advise you that the Board of Trustees of the UMWA Welfare and Retirement Fund on September 16, 1949, being faced with diminishing revenues and feeling conscious of their obligations to protect the sound operation and continuity of the Fund, adopted a resolution providing temporary suspension of payments effective after September 17. The Fund cannot, therefore, pay for any further medical services of any type after this date. Obligations already incurred will be paid. Payment will also be made for patients hospitalized prior to September 18 until they are discharged from the hospital. Suspension of these payments is a temporary expedient which will continue until funds are available for resumption of benefit payments.

We appreciate your understanding and cooperation in this matter".

This letter describes the present status of our hospital care program.

Previous to September 17, much valuable experience and information was obtained. We arranged with approximately 650 hospitals throughout the United States to render care to our beneficiaries. The Council of Prepayment Plans and Hospital Reimbursement of the American Hospital Association made specific reference to our program in their annual report for 1949. Principles were promulgated which would guide hospitals in determining acceptable arrangements with programs such as our.

They have listed four principles to determine the conditions under which special arrangements might be acceptable.

1. Point one is the guarantee of the provision of service only if the hospital has the ultimate decision of the extent of contract benefits and amount of reimbursement. Since hospitals may reject our patients, determine rates they will accept, and reopen arrangements upon reasonable notice, we have conformed with this principle.

2. Point two is, Hospitals should establish and accept contract rates of payment for service only at rates which assure a sound basis of hospital operation and which do not constitute a drain upon the hospitals' and community's resources. Fluctuating hospital costs, changes in medical practice and the development of new methods, techniques or materials in the treatment of illness require that hospitals maintain flexible arrangements for periodic adjustment of charges. We have urged hospitals to base their rates on the Reimbursable Cost Formula for an inclusive hospital day. Hospitals should not lose money on our patients, but they, in turn, should not expect us to assume the community responsibility of payment for the indigent.

3. The third principle concerns recognition of coverage. Our beneficiaries identify themselves at the admitting office of participating hospitals by means of an Authorization for Grant and a Check Stub which shows that the Authorization for Grant is current, or a Hospitalization Slip which is signed and sealed by the appropriate officers of the local union. Hospitals accept this as proof of eligibility for coverage in lieu of establishing credit especially since we pay for all services agreed upon. This conforms wholly with the principle set forth.

4. Point four is the granting of special credit privileges. It requires that subsequent discharge we pay directly to hospitals the full amount at the agreed upon rates. This, too, we are doing.

Since the program of the United Mine Workers Welfare and Retirement Fund satisfies all the provisions set forth, we have had full cooperation and, in many instances, enthusiastic reception of our policies and procedures.

The Fund prefers charges based on the Reimbursable Cost Formula for an inclusive hos-

*Presented before a meeting of the Hospital Association at Clarksburg, W. Va., Oct. 15, 1949.

pital day. We realize that some hospitals do not have sufficient data and experience to include all charges in the daily rate and, under such circumstances, other types of billing have been accepted. In all instances, we have expected rates to be reasonable and closely related to operating cost. We all know that inadequate or excessive charges will result in either a hospital or the Fund seeking other arrangements.

When we initially requested information from hospitals concerning their willingness to participate and rates to be charged, the hospitals replied in many diverse and interesting ways. Generally, they fall into these groups:

1. They would accept the rates other agencies pay under the Reimbursable Cost Formula.

2. They would accept Reimbursable Cost Formula rates adjusted to include certian costs which are not normally permitted.

3. They desired an additional percentage be added to the cost rate to cover items which do not appear on their books.

4. Some hospitals contended that their billing rates were determined on the basis of operating cost. Therefore, the billing rates should be accepted.

5. Other hospitals requested additional time to gain experience.

6. Others merely submitted their rates without comment. We have paid hospital bills when charges apparently were reasonable.

After a brief experience with our program, some hospitals suggested that we accept a daily charge instead of a detailed bill. Their reasons were:

1. That although some patients used many drugs, x-rays and laboratory procedures, others used few; nevertheless, costs could be averaged.

2. That the work in their bookkeeping departments would be simplified and reduced.

3. That income could be more accurately forecast for budgeting purposes.

4. That the medical staff could practice better medicine if the need for laboratory and x-ray services were based on clinical findings instead of the ability to pay.

We have repeatedly encouraged this attitude on the part of hospital administrators, especially when the daily rate is closely related to the actual cost.

Numerous inquiries have been received for specific fiscal and statistical information. When a sufficient and significant amount of data upon which to base an accurate appraisal has been obtained, it will be made known.

Scrutiny of the Fund's expenditures for hospital care will be, in effect, a review and evaluation of the charges made by your hospitals.

So much for general principles in our hospital program. Let us now discuss some of the principles of our relationship to the community, to hospitals, physicians and dentists as they are being worked out in West Virginia.

In administering this medical care program that we call the United Mine Workers Welfare and Retirement Fund, we have found that there are roughly five fundamental principles which must be developed in order that administrative costs to the Fund be kept to an utter minimum. Administrative costs must be kept to an utter minimum so that the bulk of the funds that are available can be used for the purchase of hospital and medical care. It is therefore equally to your interest and to ours that the administrative costs be kept at this minimum. We are, therefore, with other agencies such as doctors, nurses, et cetera who are giving medical service and care, together in this program. Our administrative costs will go up or down in accordance with requirements which your relationship with us demands.

1. First and foremost of the principles is that the unit to be served must assume a large percentage of the administrative responsibility and cost which it can absorb by voluntary effort. It can do this by assuming full responsibility for the certification of eligibility and the identification of individuals to secure this service. This we do through the local unions themselves which are closely knit organizations, capable of assuming this resonsibility.

2. The vendors of the service, i.e., doctors, nurses and hospitals, must assume responsibility for policing themselves and therefore maintaining their relationships with us on a sincere, ethical basis as well as a sound economic one. In all instances, they must render us a good quality of service at the lowest reasonable cost to us, assuming with us responsibility more through understanding than through police methods for the reasonableness of their charges. This is altogether conscionable because of the exceedingly low administrative costs, thus permitting most of the funds to go for the purchase of care.

3. The area medical office with the responsibility for the administration of the Fund must remain a catalytic agent rather than assume any police functions other than those of an ordinary buyer. In the role of catalytic agent, it can assist with development that will lead to an

improvement of the quality of medical and hospital service to the entire community as well as to its membership. It can stimulate the improvements, organization and development without becoming involved. It can coordinate all agencies so that a full, rounded medical service can be developed.

4. In the fourth place, it is our responsibility to develop a sufficiently flexible fiscal policy of payment and sufficiently minimum modus operandi to facilitate the presentation of bills or service rendered and the payment thereof. This is necessary because the commodity we are purchasing must remain flexible enough to meet human needs which are varying needs. That responsibility we have tried to assume to the fullest.

5. In our discussion, this is most important. The community's agencies set up to render services to the community and paid for either by taxes or by donation, must fully meet their several responsibilities. The tuberculosis program of the state must carry on and care for tuberculosis for all its citizens, regardless of the presence of the Fund and the possibility of its assuming some financial responsibility. The Cancer Society as an agency of the state must meet its full responsibility and turn to the Fund only when it has exhausted its possibilities. But more than these responsibilities, and this is the phase of community responsibilities on which I wish to enlarge, it must assume more responsibility for the support of hospitalization, a responsibility which the communities in this portion of West Virginia, where we are serving, do not yet understand fully.

I want to enlarge on my last comment. Hospitals, for years, have fought a gradually winning battle with the communities they are serving, to get communities to assume their full responsibility for paying full cost for those members of the community who are unable to pay for their hospitalization or able to pay only a portion of it. The indigent of a community are altogether the responsibility of the whole group of the community and not the responsibility of the five to seven per cent of the community that is hospitalized in the course of each year. Much has been done in the development of Department of Public Assistance responsibility and Crippled Children's responsibility to assist with this. However, there is still more to be done for the emergencies brought in off the street, whose hospitalization is at present, willy nilly, being assumed by the private patients of the hospital who pay more than cost. It is altogether wrong, in principle for a hospital to charge any patient, regardless of ability to pay, more than cost, and this requires that one hundred per cent in the community, through donations, tax funds or otherwise, assume the responsibility for those unable to pay in whole or in part for their hospitalization.

But more than this, there is still another cost that communities as a whole must eventually assume if their hospitalization is to reach a sound basis of community financing. It involves the fundamental relationship of the community to the hospital and the hospital to the community that is best described by an illustration I have used many times.

In this great community which we call the United States, development of the various agencies that we have in communities is pretty much as follows:

Let us picture a small crossroads community beginning to grow. At first, possibly several families came into the community and since they found they were dependent upon each other, all of the families assisted by log rollings in building each other's houses. Time went on and more and more houses grew up in the community, more and more people came to live there. At first, in these isolated communities, worship was a function of the home and family worship was the rule. Also the teaching of children was a function of the home, first taking place at the mother's knee and later by visits to the various homes by one member of the community selected to teach children. Also, the sick were cared for in the home, many times with the assistance of neighbors. When the community had grown to a certain size, the men of the community gathered together, cut the logs and built the building for the teaching of their children. Then, one member of that community gathered the children each day for schooling. The Board of Trustees were the fathers of their community and thus, there developed an extension of the home for the teaching of the children in the community.

Similarly, the men of the community cut the logs and built the building for the worship, thus developing an extension of their home for the worship of God and the teaching of their children in the ways of religion. Then, by similar means, the men of the community together cutting the logs and building the buildings, the same community set up a hospital as an extension of the patient's home where he could be cared for by the more technical, detailed methods requiring a hospital. Hospitals are just that and must always remain extension of the patient's home. They can never be totally the work shop

for the physician or the specialist although, incidentally, the physician and the specialist may do the bulk of their best work there. Whenever the hospital becomes the work shop of a physician, it becomes a business quite different from the original development. Our government early recognized this and the first volutary hospital for the care of the sick that is recorded in large communities was in Philadelphia, established by a grant of a sum of money from the City Council to which was added voluntary donations. Our government in Washington has recognized this principle in passing the Hill-Burton Act, whereby millions of men cut logs to build many hospitals in many communities. This was found necessary in view of the development in the country and the costliness of building and equipment but the principle is the same and such hospitals must be developed as extensions of the patient's home.

But why is there this desire to have a hospital in the community? It must be an essential service. If it is an essential service which the community must have, then the community has certain responsibilities for the payment of the costs of having it in the community. More specifically, the costs of having the hospital in the community or its 'readiness to serve' cost, regardless of any patient that may be in it, is therefore a responsibility for the whole community. You know as well as I do that at the present time, patients admitted to the hospital are the ones asked to bear this cost of 'readiness to serve' and in doing so, the community is asking between five and seven per cent of its population, who are sick and therefore in poorer circumstances, to pay for the basic 'readiness to serve' or upkeep cost of having the hospital in the community for the service of all.

In this connection, I use another analogy. Most communities have, through tax funds, set up a fire department for the purpose of putting out fires. They do not ask the individual citizen, whose house is burning down to pay for the service rendered or the upkeep of the department. In my analogy, the hospital may be likened to a private fire department, an essential service, when called upon by one of the citizens to put out a fire, runs to the fire but on arrival at the scene of the fire, seeks out the owner thereof and asks him to put down $50.00 before they will put out the fire. When patients are sick, their house is burning down. Why does the hospital have to assume this attitude? It is because the community as a whole, in many instances, does not know that such is their responsibility and in many instances, our hospitals equally do not know that they should ask the community to assume such a responsibility. In fact, there are many hospitals in this section that do not know what their 'readiness to serve' cost is because their books have not been kept to show such costs.

Work has been done demonstrating that certain items of hospital cost are justifiably 'readiness to serve' cost. A basic article appeared in "Hospitals" approximately a year ago, setting forth the items that would ordinarily become 'readiness to serve' cost. Roughly, these are a certain percentage of the coal used to warm the hospital in the course of the year, a certain percentage of the utilities, electricity, telephone and maintenance costs, certain percentages of the salaries of certain key people necessary to hospital administration and service to the first patient that is admitted. In general, with the fifty bed hospital, this amounts to from twenty-two to twenty-five per cent, while with the larger hospitals, up to one hundred and fifty beds, it may drop to eighteen per cent, but basically, this cost is the cost of just having the hospital in the community with the key personnel making it possible to take in the first sick patient and this cost should conscionably be borne by one hundred per cent of the membership of the community in accordance with their ability to pay, rather than the five to seven per cent who use our hospitals in the course of the year.

The method can vary with each community as to whether it is tax funds, Community Chest funds, or donations. If the community met this responsibility, costs to patients could be lowered to where they would be within reach of a larger percentage of the community. Concomitantly, there will be fewer members of the community unable to pay all of their hospital service because now they would be paying for the service that was rendered to them only.

Therefore, as part of the fifth principle, namely the assumption of the community of its full responsibility, I present you with the 'readiness to serve' cost as a cost the community must also fully assume. All of us have a teaching responsibility in this connection but first we must know whereof we speak in our individual instances. We must set up our books so that at the end of a year or a period, we can say that this amount represents 'readiness to serve' and therefore, a cost to the community as a whole. We must teach that we have no right to charge the five to seven per cent for this cost except in so far as the community does not assume the responsibility and, each year, we must present these figures from our books as to 'readiness to

serve' costs to the community so that they know they have not fully assumed responsibility.

I present you, therefore, with the same evidence that the fire department has to show the community how its money has been used. You have seen the fire department bring out its equipment and machinery to show the purchases that have been made, but have hospitals brought out before the community the itemization of their 'readiness to serve' cost to show the community how their dollars for 'readiness to serve' were spent or would be spent if they met their full responsibility? Unless hospitals begin now to teach this responsibility to the community, we will never get it across and if we go at this job to teach it, even then, it will take us years just as it has taken us twenty years to get a Hill-Burton Act and longer to get community recognition of the need to pay full cost for services to the community's indigent. The plan is workable and practical but we must hold our eyes on the end to be attained, and not be diverted by minor difficulties. It will take time to get this message across to our community but unless we make a start, we are not fulfilling our responsibility as hospitals or as agencies serving the public, regardless of whether we are community type hospitals, voluntary hospitals or proprietary hospitals.

When this millennium is reached, and I have full confidence that it will be reached, because in this democratic land of ours, developments may come slowly but they come just as surely, hospitalization costs to the individuals will come down and also to Blue Cross plans and Welfare Funds, it will be possible for all agencies to pay full cost. So, we feel that in this connection your fight is our fight.

We have given much thought as to how the impact of this great organization could be made to bring about the highest quality of medical and hospital service to all of the members of our communities and therefore, incidentally, to the miners whom we are serving. We, Mr. Mayers and I, have generally outlined this program of the United Mine Workers Welfare Fund. We will push toward our objectives with full sincerity and we hope you will find that this program has become a factor for the development of all agencies in the community. We have also pointed out the ways where we can work together to attain some of the ends which have been discussed.

Sixty-six per cent of persons over 75 years of age in this country die from cardiovascular-renal diseases.—J. F., in Ohio St. Med. J.

TOWARD EFFECTIVE CANCER CONTROL

By CHARLES S. CAMERON, M. D.
Medical and Scientific Director
American Cancer Society
New York City

Nowhere in the world do voluntary health agencies flourish in such abundance as they do in the United States. They are an expression of the charitableness of our people toward those less fortunate, and they are testimony to the democratic spirit of Americans in organizing and working cooperatively for the common good.

The American Cancer Society, a venerable member of the family of health agencies, should be thoroughly known to all doctors for its services are many. Through its national office in New York, its 61 chartered divisions and 2,613 county branches, it conducts a broad-based year-round effort to control cancer, one of the foremost medical problems confronting us.

The control of cancer eventually will come through an understanding of cancer's causes, means of prevention and effective treatment methods; this knowledge waits on research. The Society has recognized the importance of intensified investigative efforts in the field of growth and spends 25 per cent of its income in the support of such studies and in the training of young scientists to carry them forward. During the present year this support amounts to $3,500,000. The total research expenditure for the past five years is $13,153,560.

A substantial measure of control over cancer can be achieved today with the knowledge already at hand. The disparity between cancer's curability and the cures being achieved is striking. For example, cancer of the breast is curable in 80 per cent of patients who are treated when the disease is confined to the breast; yet the country-wide cure rate is less than 35 per cent. When cancer of the rectum is confined to the mucosa, cure rates of 70 per cent have been reported; yet the overall rate of cure is about 11 per cent. Similar differences hold for most forms of the disease.

In order to achieve a larger measure of cures, the American Cancer Society engages in an intensive educational and publicity campaign, based on knowledge of cancer's early signs and symptoms (the Danger Signals), and the value of periodic physical examinations.

April is the month when the American Cancer Society makes its annual appeal to the public for support of its programs. As more and more of our people live longer, the incidence of cancer increases. As the problem be-

comes more widespread, so must the effort to control the disease be intensified. The Society is dedicated to the principle that through education and research an effective measure of cancer control may be achieved at this time.

Improved services to patients with cancer are provided by support of cancer clinics, organized programs of cancer detection, and information services. These efforts are augmented by a corps of volunteers who provide loan closets, transportation services, recreational activities and dressings.

Of immediate interest to doctors is the professional education program. During the past year, three monographs of a series dealing with cancer by anatomic site have been distributed to practicing physicians throughout the country. The series will be continued this year, with distribution at three-month intervals.

The professional journal CANCER, which first appeared in May, 1948, has been well received by clinicians and investigators interested in the problems of abnormal growth. A series of motion pictures for professional audiences, treating the problems of early diagnosis of cancer by anatomic site, has been outlined. Two of the films have been released, the first concerned with the general problem of the early diagnosis of cancer and the second concerned specifically with the early diagnosis of cancer of the breast. A third, covering cancer of the gastro-intestinal tract, is in preparation and will be released this year.

A new publication of the Society will appear this year, and will be distributed bi-monthly to practicing physicians throughout the country. Topics of interest to the general practitioner will be presented in digest form, together with brief abstracts of significant papers appearing in the literature. Clarity, brevity and general interest will be stressed. It is the Society's hope that this digest will be accepted by the busy physician for whom it is planned.

The library of the Society publishes monthly a bibliography of the current cancer literature which is available on request to physicians, research workers and libraries. The library will prepare, on request, bibliographies on any topic related to the filed of cancer. A package lending library has been established which will supply reprints, on a loan basis, to any physician or investigator requesting the service.

We have only about 900,00 acceptable hospital beds, outside of federal hospitals, in the entire country, against established need for twice that number.—R. N.

EBB AND FLOW OF IDEAS IN MEDICINE

In these days of frequent new medical discoveries, due mainly to the germination of new ideas and new techniques, to some extent associated with the stimulus of the late war, it is perfectly obvious that many of the recent discoveries are really new and are not revivals of ideas or techniques which have passed into oblivion and have recently been resurrected.

So far as I know no one before the present generation was acquainted with the therapeutic value of the sulfa drugs or of the numerous "antibiotics": Penicillin, streptomycin, aureomycin, for example, which have recently been discovered. There are no doubt some modern drugs, knowledge of which was foreshadowed long before they came into existence, at least in their modern and more potent forms.

Both Addison and Niemeyer were acquainted with the diuretic effect of mercurials, for the pills for the alleviation of heart failure which bear their names both contined that drug, and this long before the much more active mercurials now in use were accidentally discovered in the search for antiluetic medication. Osler in his youth wrote an article on the diuretic affects of calomel. Years before the effect of quinidine on cardiac conditions was widely publicized, a favorite recipe of the cardiologist Theodore Schott was a mixture of equal parts of powdered digitalis leaves and quinine sulphate.

No doubt many other such incidences could be cited, not only in therapeutics but in other fields of medicine. Indeed one wonders how, before the days of the Catalogue of the Surgeon-General's Library and the Index Medicus and its successors, anyone, even the most omnivorous reader of medical literature, could keep cognizant of the published advances in medicine, and there were always unpublished ones too.—Connecticut State Medical Journal.

THE GP AND THE PATHOLOGIST

Undoubtedly the most important fields in which the pathologist can be of assistance to the general practitioner are in tissue diagnosis, both surgical and postmortem, hematology, bacteriology, and serology.

More and more surgical procedures are being performed in the smaller hospitals, especially in rural areas. It is just as essential, for the protection of the public and the professional growth of the surgeon, that tissues removed at operation in the small hospital be examined by a pathologist as in a large hospital. Likewise, the postmortem examination is as necessary a procedure in the small hospital as in the large hospital if the staff members are to profit by errors in diagnosis, evaluation of therapeutic measures employed, and a discussion of the pathogenesis, symtomatology, diagnosis, and treatment of a given disease.

The clinical-pathological conference, conducted by the pathologist, who has the surgical or postmortem material at hand for demonstration, can be as stimulating an event in the small hospital as in the large hospital.—L. W. Larson, M. D., in South Dakota J. Med. and Phar.

TUBERCULOSIS ABSTRACTS*

TB—THE COSTLY DISEASE

If tuberculosis is to be eradicated, adequate facilities must be made available for chest x-rays of all apparently healthy adults, for suitable follow-up of all cases needing further study, and for medical care.

Sufficient hospital beds must be made available to insure care and isolation for all persons with active disease; adequate financial provision must be made for the families of hospitalized patients; funds must be at hand to insure the rehabilitation of ex-patients. Above all, health education must be carried to a far greater proportion of the population. Medical research must continue on many fronts. Pensions must be provided for tuberculous veterans. All these facilities and activities require vast sums of money both from official and voluntary sources.

Best estimates indicate that in 1948 the tuberculosis control program in the United States cost approximately 350 million dollars. This amount makes no allowance for hospital construction, for depreciation of hospital buildings, or for the training of professional personnel.

The Public Health Service appropriation for tuberculosis control is now about ten million dollars annually; the Christmas Seal Sale is more than 20 million dollars; state health department funds for tuberculosis work have increased materially in the past decade. The Veterans Administration is now spending much more on hospitalization and rehabilitation of the tuberculous. Pensions for veterans whose major disability is tuberculosis amounted to 86 million dollars in the calendar year 1947.

Not only are official and voluntary health agencies spending huge amounts on community-wide x-ray surveys, but industrial firms and labor unions are financing projects of this type. Moreover, in recent years it has become necessary to devote large sums to the recruitment and training of executive and professional health workers.

In addition to the estimated annual cost of approximately 350 million dollars, so-called "hidden costs" of tuberculosis will run well into the hundreds of millions. Among these costs are the potential annual losses in wages, in production, and in net future earnings incurred by those persons who die or are incapacitated by tuberculosis. Since these estimates overlap to some extent, no total can be shown for potential losses of this type.

A study made in 1943 estimated that the potential loss of wages in that one year by those who were ill or who died of tuberculosis was nearly 200 million dollars. The potential loss of goods and services which might have been produced in that year was 350 million dollars. There is, in addition, a potential loss in the net future earnings of those who died in 1943 which came to more than 200 million dollars.

None of these estimates makes any allowance for the cost of the many thousands of new beds needed. This cost would come to approximately 200 million dollars for about 40,000 new beds; if the 80,000 beds, said by certain authorities to be needed, were to be built, the estimated cost would be 400 million dollars. Such an enormous outlay may be considered justified, even in the face of a rapidly falling tuberculosis death rate, since at the end of a decade or two the hospitals would be available for chronic disease patients. Such facilities will become increasingly necessary since our population is aging rapidly. Moreover, in view of accelerated world travel, it will still be necessary some years hence to appropriate a moderate amount to maintain hospital and other facilities for tuberculosis control.

The tuberculosis death rate has now dropped to 30 per 100,000 population in the country as a whole, compared with a rate of 194 in 1900. The sensational decline in the over-all mortality rate from this disease during the past five decades has tended to obscure the fact that the death rate varies widely according to sex, age, color, economic status, and locality. Thus, the death rate of 30 must be accepted as an average only.

Mortality from tuberculosis is twice as high among men as among women. It increases directly with age and is especially high among older men. The death rate among Negroes is three times as high as among white people. In one state, the death rate is still 100, while one or two state now have rates of less than 10. Similarly, a few of our large cities have outstandingly high rates. Mortality is seven times as high among unskilled laborers as among professional persons. Thus it is evident that in numerous groups a great deal of concentrated effort must be exerted if the disease is to be brought under control at any time in the near future.

For all these reasons, the cost of tuberculosis control cannot be lessened in any community until its tuberculosis death rate reaches a level of less than 10 per 100,000. When that goal is attained, it is possible that much of the available funds may be diverted to other phases of health work. Until then, no let up can be planned.

Editorial, Mary Dempsey, Statistician, National Tuberculosis Association, Bulletin of the National Tuberculosis Association, December, 1949.

*Issued monthly by the National Tuberculosis Association and furnished through the courtesy of The West Virginia Tuberculosis and Health Association.

THE PHYSICIAN'S JOB

The physician's job is more than cutting with a scalpel, writing a prescription, giving shots with a syringe, or laboratory testing to satisfy our insecurities so that we may pigeon-hole a patient with a label.

It is more tantamount and paramount, as Osler said, that "The practice of medicine is an art, not a trade, a calling in which your heart will be exercised equally with your head. Ofter the best part of your work will have nothing to do with the potion and powders, but with the exercise of the influence of the strong upon the weak, the righteous upon the wicked, the wise upon the foolish."

When we are as truly worthy of our station as the physician in Luke's painting we shall not have to be afraid of socialized medicine ever coming.—H. H. Kato, M. D., in Rocky Mt. Med. J.

The President's Page

Those of us who were privileged to attend West Virginia's first press-radio conference sponsored by the public relations committee of the State Medical Association, called primarily for the purpose of improving relations with both the press and radio, will most certainly agree that the event proved to be a forward step in this direction. The attendance from each group is proof positive that there is mutual interest in the problems which were discussed very frankly at the meeting.

I venture to voice the hope that the conference in Charleston on March 12 will be but the first of a long series of similar gatherings which could well develop into one of our most important annual state meetings. The press and radio have been very generous in their comments concerning the meeting, and there is no doubt that the matters presented will be referred to both the Council and the House of Delegates for proper consideration. It is most gratifying to me to know that all but three of our component societies have an active public relations committee, headed by a chairman who is working hand in hand with the state public relations committee.

Two very important meetings are being held the latter part of March. One is the interstate medical meeting at the Greenbrier, White Sulphur Springs, March 29, which is being sponsored by the Alleghany-Bath Medical Society (Virginia) and the Greenbrier Valley Medical Society. The other is a public health conference at Morgantown, March 31-April 1, arranged and sponsored by the School of Medicine at West Virginia University.

Both of these meetings will be history when this issue of the Journal is delivered. Their importance to the medical profession cannot be over-emphasized. I hope that our various component societies may give consideration to the development in the future of plans for similar conferences in other parts of the state.

C. E. Watkins

President.

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Managing Editor
Mr. Charles Lively ..... Charleston

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R. H. Edwards, M. D. (1953) ..... Welch
W. M. Sheppe, M. D. (1954) ..... Wheeling

Editor Emeritus
James R. Blass, M. D. ..... Huntington

Business Manager
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PHYSICIANS, REGISTER AND VOTE

The laxity with which many classes in the United States register and vote is appalling. Mr. Charles S. Nelson, executive secretary of the Ohio State Medical Association, speaking before the Second Annual Conference sponsored by the American Medical Association, in connection with the National Ohio Education Campaign, discussed some statistics.

After the 1948 presidential election, the registration and voting list of one of their large counties which includes a very large industrial area disclosed the following startling facts:

"18% of the physicians in the county did not vote in the 1948 election—13% of them were not even registered and therefore not eligible to vote.

22% of the wives of physicians did not vote—16% of them were not registered.

10% of the members of the Rotary Club did not vote—3% were not registered.

The tally on Kiwanis Club members was about the same.

18% of the druggists did not vote—15% were not registered.

11% of the teachers did not vote—6% were not registered.

32% of the bank employees, including executives, did not vote—26% were not registered.

33% of the ministers did not vote—26% were not registered.

34% of the retail grocers did not vote—29% were not registered.

21% of the members of the Chamber of Commerce did not vote—15% were not registered."

These groups of our citizenship certainly represent a segment of the population which has had most training in citizenship. These figures are appalling. When we howl about politicians and bad government, are we ourselves without sin?

Every physician in West Virginia should register and vote at every election, primary and general.

CAMP FOR DIABETIC KIDDIES

There is little doubt in the mind of every physician that the diabetic children of our state need the advantages of a vacation from the routine of every day life that becomes more burdensome to them than it does to healthy children, the routine of special medical care, restricted diet and insulin injection. It is unfortunate that in the past the advantages of camp life have been denied the diabetic child whose very life is dependent upon such restrictions. Because these facilities are not available in the ordinary camp, the diabetic child has had to remain at home when his siblings and playmates have gone away for a happy summer vacation.

Not only does the diabetic child need the benefit of out-door exercise and sunshine, but also help and understanding with his psychological problems. He is likely to be introspective and feel dependent and sorry for himself because of the restrictions and the dicipline that his diseases places upon him. Even if the child would not be inclined toward this attitude of self pity, his parents may inflict it upon him. The child, however, represents only part of the problem.

The small child with diabetes naturally can not guide and control his own destiny and, therefore, his parents have assumed that responsibility for him. They are very often tired, discouraged and worried, sacrificing their lives, unable to be free of their arduous task, even for a day. We soon realize that there is a double problem connected with the treatment of the diabetic child, the care of the child and the care of the parents.

This year for the first time in West Virginia a summer camp will be available for diabetic children, a camp which will enable the parents

to shed their arduous responsibilities for one week. This summer camp will not only constitute a summer vacation for the children, but in addition will be an extension of hospital services because the children will be watched and regulated as closely as they would be in the hospital. Proper diet planned by dietitians, nursing care and medical supervision, and laboratory testing will be available. Camp councilors, both men and women, will direct the recreational program.

In this camp there will be no class distinction, because admission will be gained simply by the submission of an application.

There will be no charge, the camp site and equipment having been donated by Carbide & Carbon Chemicals Corporation, of South Charleston. The services of camp personnel, including doctors and councillors, will be donated. The necessary running expenses will be paid for by grants from interested individuals and organizations.

The use of Camp Cliffside as a summer camp for diabetic children from August 26 to September 2, 1950, will be a mile-stone of progress in the treatment of diabetes in this state. West Virginia will be the ninth state to offer such advanced medical facilities. In these times, no project could do more to improve public relations.

LOCAL MEDICAL HISTORY

The medical profession of the United States has neglected to present properly its history in the various local areas, but every now and then an outstanding work on the medical history of a locality comes from the press. Such a work has recently been issued by the University of Florida Press. The book, "A Century of Medicine in Jacksonville and Duval County", from the pen of Dr. Webster Merritt, is, to us as least, the most interesting medical history of a local community since the publication of Blanton's monumental History of Medicine in Virginia. It covers the period from the late seventeen-nineties to 1900.

The book is well written in entertaining style and is a history not only of medicine but of medical and sanitary development as well. In fact it casts much light on the lay history of the region also. One of the most charming incidents depicted is the story of the doll filled with morphine and quinine which was smuggled through the Union lines for use of the sorely beleaguered Confederates.

We admit disappointment at the mere mention of John Gorrie whose therapeutic experiment to lower the temperature around the bodies of his malarial patients has resulted in the modern science and industry of refrigeration. However, Dr. Gorrie was a resident of Appalachicola and, as far as our knowledge goes, never resided in Jacksonville.

Dr. Merritt, the author, is an outstanding internist of Jacksonville and has long been a student of Florida history. We congratulate him on the splendid work he has done, and commend his example to the profession throughout the United States, hoping that physicians in other localities may "go and do likewise".

THE A. M. A. AND EXCESSIVE FEES

At a recent meeting in Chicago, the Board of Trustees of the American Medical Association issued a very frank statement vigorously opposing excessive fees charged by some physicians. They say, "The Board of Trustees looks with disfavor on the few members of the Association who charge excessive fees. It urges state and county societies to discipline those members who, after a fair hearing and a decision that the fees charged have been excessive, refuse to reduce their fees to a level that is reasonable for the services rendered."

The full statement, signed by Dr. Louis H. Bauer, Chairman of the Trustees, and by all members of the Board, appeared in the Organization Section of the February 25 issue of the Journal.

CAREFUL, POLITICIANS

Winston Churchill, because of his war association with Franklin D. Roosevelt, has a large place in the hearts of the American people who rejoice at the gains his party made in the recent British election.

It would appear that in this election the socialistic attitude of the government has met a rebuff. It is said the "Scheme," the British socialized medicine law, is unpopular not only with the people but with those who must enforce it and this is one of the reasons for conservative gains.

There is a lesson here for some of our politicians who are wanting a socialized medicine act.—J. Alfred Taylor in The State Sentinel.

As a man thinketh in his heart, so is he.—Solomon.

GENERAL NEWS

PROGRAM COMMITTEE FINISHING PLANS FOR 83RD ANNUAL MEETING JULY 27-29

The program committee which is making arrangements for the annual meeting at White Sulphur Springs, July 27-29, is meeting in Morgantown on March 23, and it is possible that the formal scientific program will be completed shortly after the first of April.

Dr. H. B. Mulholland, head of the department of medicine at the University of Virginia, will appear on the program July 29 and will discuss "The Use of the Newer Insulins". At the same session, Dr. Frank Lahey, of Boston, Dr. Philip Thorek, of Chicago, and Dr. Earl Baxter, of Columbus, will appear as guest speakers.

Doctor Mulholland is well known in West Virginia. He is a member of the AMA Council on Rural Health, and will attend the statewide rural health conference late this spring which is being sponsored by the state public relations committee.

Doctor Lahey's subject will be "Lesions of the Terminal Ileum, Colon and Rectum." Doctor Thorek will discuss "The Acute Abdomen," and Doctor Baxter, "Common Respiratory Infections in Children."

Doctor Baxter is professor of pediatrics and head of the department at Ohio State University School of Medicine.

Another speaker, Dr. Allan C. Barnes, also of Ohio State University, has accepted an invitation to present a paper on July 28, the second day of the meeting. His subject will be "The Use of Estrogenic Hormones in Clinical Practice." Doctor Barnes is professor of obstetrics and gynecology at Ohio State University.

MCV Staff To Present Program

The entire scientific program on Thursday, July 27, will be presented by the staff of the Medical College of Virginia. The program for the opening session is being arranged by Dr. Kinloch Nelson, director of continuation education. It is probable that the time will be divided among four speakers, with a panel discussion following the last address.

A panel discussion is also scheduled for Friday following the program which will feature addresses by three speakers, including Dr. George M. Curtis, professor of experimental surgery at Ohio State. His subject will be "Modern Treatment of Thyroid Diseases."

The arrangements for section and society meetings will follow generally the plan used at the meeting at White Sulphur Springs in 1949. All afternoon meetings will begin promptly at 2:30 o'clock, and there will be no special luncheons or dinners unless a request for the same is made by special groups.

The annual Medical College of Virginia Alumni dinner is scheduled for the evening of July 27. Arrangements for this event are being made by Mrs. Helen M. Seller, of Richmond, assistant secretary of the Association.

The address of the president, Dr. C. E. Watkins, is scheduled for the first evening at 8:45 o'clock, and Mrs. Dana T. Moore, of Parkersburg, president of the state Auxiliary, will also appear on the program.

AMA President on Program

Dr. Elmer L. Henderson, of Louisville, Kentucky, president of the AMA, will be the guest speaker at an open meeting on Friday evening. His appearance will mark the first time in several years that a president of the AMA has attended an annual meeting.

The banquet will be held Saturday evening, and the main attraction will be the Weirton Steel Male Chorus, which will present a musical program. This famous chorus appears through the courtesy of the Weirton Steel Company.

Golf and tennis tournaments are being arranged. and play will be limited to afternoons. Trophies will be presented at the banquet. Dr. R. R. Summers of Charleston, is chairman of the golf committee, and the tennis tournament is being arranged by Dr. Spencer L. Bivens, of Charleston.

The entire program is being arranged by the scientific work committee, composed of Dr. J. P. McMullen, of Wellsburg, chairman, and Drs. E. J. Van Liere, of Morgantown, dean of West Virginia University School of Medicine, and Dr. Richard E. Flood, of Hollidays Cove.

HEALTH DEPARTMENT APPOINTMENTS

Dr. B. M. Drake, Director of Rockingham-Caswell Health Department, Wentworth, North Carolina, has been appointed by Dr. N. H. Dyer, State Director of Health, as deputy health officer, effective April 1. He will assist the director in administering all of the medical programs of the department with the exception of disease control. He will also serve as medical director of local health services.

Doctor Dyer has also announced the appointment of Dr. Henry C. Huntley, of Michigen, as director of disease control, effective May 1.

Both positions are included in the reorganization program of the state department of health approved at the 1949 session of the legislature.

Doctor Drake has been in public health work since 1937. He is a graduate of Vanderbilt University School of Medicine, Nashville, Tennessee. He has been located in North Carolina since 1940, received his degree of M. P. H. from the University of North Carolina in 1947, and was certified in 1949 by the American Board of Preventive Medicine and Public Health.

Doctor Huntley is a graduate of Washington University School of Medicine, St. Louis, and received his degree of M. P. H. from the University of Michigan School of Public Health. He is also a member of the American Board of Preventive Medicine and Public Health. He began his public health work in 1942 as a health officer in Oklahoma, and for the past four years has been serving as a health officer in Michigan.

The objective of geriatric medicine is to add breadth and depth, rather than mere length, to life; and most of the progress so far has been in laying the unspectacular but necessary foundation.—J. F. in Ohio St. Med. J.

DR. ELIZABETH McFETRIDGE HEADS WEST VIRGINIA CANCER SOCIETY

Dr. Elizabeth McFetridge, of Shepherdstown, was elected president of the West Virginia Cancer Society at the annual meeting held at the Kanawha Hotel, in Charleston, February 23, 1950. She succeeds Dr. Chauncey B. Wright, of Huntington.

Other officers were elected as follows: Vice chairman, Philip Gibson, Huntington, secretary, J. Ross Hunter, Jr., Charleston, and treasurer, Homer Gebhardt, Huntington (reelected).

New Board of Directors

The following is a complete list of the board of directors elected at the meeting: John W. Yost, M. D., Bluefield; J. Ross Hunter, Jr., Arthur B. Koontz, Mrs. Stanley C. Morris, W. G. J. Putschar, M. D., and E. W. Squire, M. D., Charleston; J. M. Brand, M. D., Chester; C. L. Leonard, M. D., and Mrs. W. Grady Whitman, Elkins; Mrs. James D. Francis, Cole D. Genge, M. D., Philip P. Gibson, Raymond Salvati, and Chauncey B. Wright, M. D., Huntington; Thomas Bess, M. D. Keyser; J. Lester Patterson, M. D., Logan; M. L. Hobbs, M. D., Morgantown; F. L. Blair, M. D., Parkersburg; Hu C. Myers, M. D., Philippi; J. R. Schirmer, D. D. S., Point Pleasant; Elizabeth McFetridge, M. D., and Mrs. E. L. Goldsborough, Shepherdstown; Mrs. D. N. Thomas, Weirton; and Mrs. F. W. Klos and John P. Young, M. D., Wheeling.

Executive Committee

Dr. Chauncey B. Wright, of Huntington, heads the new executive committee, and the other members are as follows: Thomas Bess, M. D., Keyser; J. Ross Hunter, Jr., Charleston; Homer Gebhardt, Huntington; Philip P. Gibson, Huntington; Mrs. John S. Harvey, Huntington; Elizabeth McFetridge, M. D., Shepherdstown; Frank V. Langfitt, M. D., Clarksburg; Hu C. Myers, M. D., Philippi; W. G. J. Putschar, M. D., Charleston; Mrs. D. N. Thomas, Weirton; and N. H. Dyer, M. D., Charleston.

Mrs. Harvey and Mrs. Seletz Reelected

Mrs. John Speed Harvey, of Huntington, and Mrs. A. A. Seletz, of Charleston, were reelected state commander and deputy commander, respectively.

Prominent Speakers on Program

Dr. Thomas Bess, of Keyser, retiring chairman of the executive committee, paid tribute to the very fine work of the late Russell B. Bailey, M. D., of Wheeling, who was president of the West Virginia Cancer Society at the time of his death on September 15, 1949.

Robert O. Purves, of New York City, director of the American Cancer Society field organization, was one of the guest speakers at the annual dinner on February 23.

Dr. Charles S. Cameron, of New York City, medical director of the American Cancer Society, the other guest speaker at the dinner, spoke on the subject of "Paradoxes of Cancer." The evening program ended with the showing of the sound motion picture, "To Save These Lives."

According to Mr. Purves, approximately 350,000 new cases of cancer will be discovered in the country during the next year, with cures being effected in about 80,000 cases.

The speaker reported that a recent survey made by the University of Michigan disclosed that 80 per cent of the persons questioned recognized cancer as a dangerous disease, but that only 37 per cent reported they had contributed to last year's cancer fund. He said that more than $7,000,000 has been allocated by the American Cancer Society for cancer research since 1945, approximately 25 per cent of all funds collected being used for this purpose.

Interesting "Cancer Institute"

Dr. S. Roger Tyler, rector of the Trinity Episcopal Church, in Huntington, was the guest speaker at the luncheon on Friday. The luncheon was held following an interesting "cancer institute" in charge of Mrs. John Speed Harvey and Mrs. A. A. Seletz. The directors of six cancer information centers in the state participated in the discussion. Mrs. C. D. Ellifrits, of Elkins, state PTA president, spoke on the cooperation of public schools in health programs. A workshop on the cancer program was conducted by Mrs. Fred M. Alexander, of Richmond, Virginia, deputy national commander.

SPECIAL PROGRAM, APRIL 11, IN KANAWHA

The regular monthly meeting of Kanawha Medical Society, scheduled for April 11, at the Daniel Boone hotel, in Charleston, will consist of a scientific program only, to begin at four o'clock in the afternoon.

The first speaker will be Dr. J. H. Mitchell, of Chicago, president of the American College of Allergists, who will discuss "Allergy and the Emotions." He will be followed at five o'clock by Dr. Leon S. Smelo, of Birmingham, Alabama, whose subject will be "Insulin Resistance."

The evening program will begin at eight o'clock, and will be held in the ballroom at the Daniel Boone. At that time Doctor Smelo will address an open meeting. His subject will be "A Quarter Century of Diabetes."

At 8:40 o'clock, Doctor Mitchell will discuss "Can Worry Make Me Sick?"

An invitation has been extended by Kanawha Medicall Society to all members of the West Virginia State Medical Association to attend these sessions, as the subjects to be discussed are considered to be of general interest. The public is invited to attend the evening session with members of the medical profession.

AM. ACAD. OCCUPATIONAL MEDICINE ELECTS

Dr. C. L. Savage, of Waynesboro, Virginia, was elected president of the American Academy of Occupational Medicine at the second annual meeting, in Cincinnati, February 17-18, 1950.

Other officers were elected as follows: Vice president, Dr. Frank M. Jones, Montreal, Canada; secretary, Dr. Leonard J. Goldwater, New York City; and treasurer, Dr. A. F. Mangelsdorff, Bound Brook, New Jersey.

MORE THAN 50 REPRESENTATIVES OF PRESS AND RADIO AT CONFERENCE

The Radio-Press Conference at the Daniel Boone Hotel in Charleston March 12, sponsored by the West Virginia State Medical Association and in charge of the state public relations committee, drew an attendance of 55 representatives of the press and radio in this state. In addition, every member of the state PR committee was present with one exception, and all of the officers of the State Medical Association sat in on the entire session. The conference was the fifth of its kind to be held anywhere in the United States.

The Conference was unique in that no doctor appeared on the formal speaking program, but the panel which sat for a question and answer period was composed of officers of the State Medical Association, members of the PR committee, Dr. N. H. Dyer, state director of health, Dr. E. J. Van Liere, dean of the West Virginia University School of Medicine, and Larry Rember, director of public relations for the American Medical Association.

Dr. Frank J. Holroyd, of Princeton, was chairman of the meeting, and in welcoming the guests said that the members of the medical profession for years had had drilled into them the importance of avoiding any kind of publicity as they would avoid the plague under penalty of being labeled an "advertising doctor".

The chairman said that the doctor-patient relationship, and the necessity for maintaining this relationship, had resulted in some misunderstandings with the press, which he hoped could be ironed out at the conference. "The object of the meeting," he said, "is to have both sides present their problems and make recommendations so that a plan may be worked out, if possible, that will be acceptable to both groups."

Short Speaking Program

The formal speaking program consisted of short addresses by the following representatives of the press and radio in West Virginia: Daily newspapers, Francis P. Fisher, editor, The Parkersburg News, and president of the West Virginia State Newspaper Council: weekly newspapers, Joseph W. Short, editor, The Ravenswood News; industrial and trade journals and professional publications, W. C. Handlan, editor, Monongahela News, Fairmont; The Associated Press, Lee Garrett, member of staff, Charleston; United Press, Vic Jacobs, bureau manager, Charleston; and radio, John S. Phillips, manager WCAW, and president of the West Virginia Broadcaster's Association.

Dailies and Weeklies

In speaking for the daily newspapers, Francis P. Fisher discussed briefly the matter of what constitutes advertising on the part of doctors. He stated that it is very hard for a newspaper to know where to draw the line between news and advertising in its relations with the profession.

Joseph W. Short, representing weekly newspapers, stated that it is hard to differentiate between what can legitimately be treated as news or charged for as advertising.

He spoke of the service of the newspapers to the community and the medical profession in reporting the return to practice of West Virginia doctors who served with the armed forces during World War II. These notices were inserted without charge in many of the newspapers.

(Ed.: Several component societies of the State Medical Association periodically inserted paid advertisements in the local papers with reference to the return to practice of members servinig with the Medical Corps).

He stressed the importance for a better understanding by doctors of the need for more detailed information to complete a newspaper story, accurate data being required, especially in reporting accidents.

If the American Medical Association, in its National Education Campaign, decides to use advertisements in the papers, then he urged that weekly newspapers be used in order to get the message down to the "grass roots."

Industrial Journals

William C. Handlan reported that many industrial publications are featuring articles and editorials in support of the American system of free enterprise. He noted that particularly in his own industry a switch from a limited approach to a broader view of the picture.

Mr. Handlan recommended that the approach to the industrial press from the standpoint of medicine be on a broad front of public interest, with medicine showing an understanding of, and sympathy with the problems of industry, rather than "on the narrow front of opposition to socialized medicine, a stand which is so frequently given a selfish construction."

The Associated Press

Lee Garrett, representative of the Associated Press, said that he thought that the best thing that has happened to the medical profession in years is the threat of socialized medicine, because that threat has been responsible for the doctors looking into many things which were formerly taken for granted.

Speaking of his acquaintanceship with doctors, he said that, in his opinion, they are without exception as personable and pleasant a group of individuals as he had ever had the pleasure of meeting. "But, collectively," he said, "you have bound yourselves up in a set of rules and regulations, real and implied, which not one of you individually dares to violate. Collectively, you present a formidable wall which scares us, and which we frequently do not attempt to scale.

"Let's break down that fear. Let you not be afraid of newsmen and the work they do, even though it may mean getting your name in the paper now and then. You probably like it except for those hidebound rules. Everyone else seems to."

The speaker expressed the thought that newsmen should be permitted to feel that doctors can be approached professionally without fearing that "we are bearding an ogre in his den, and with some assurance that we can get what we came after."

"The thing that people are most interested in is people," he said, "and the things that people are most

interested in are the simple, elemental things, life and death, sickness and health—the answer to the age-old greeting, 'How are you?'" Saying that there isn't a single group of men in the world who possess so rich a store of simple human interest stories as doctors, he asked, "Why keep them bottled up?"

The speaker said that drama in a doctor's life, such as saving a child from choking to death, is still news. He cited the fact that the so-called blue baby operation still has a strong public appeal. He cited as news, the use of improvised instruments a doctor is often called upon to use instead of the specially designed tools available to him in an operating room.

Mr. Garrett strongly urged that every doctor, no matter how busy he may be, take time to talk with a newsman. "Can you think of any good reason why a doctor's name should not be used in a news story?" he asked. "Credit should be given where credit belongs. A physician's name stands as authority for his statement. It certainly reads more smoothly to say that 'Dr. John Jones said' than to say that a physician who asked that his name not be used said thus and so."

The Radio

John S. Phillips, speaking for the broadcasting companies of West Virginia, called for a better relationship from a news standpoint between the medical profession and the press and radio. He reported that as a public relations service, broadcasting companies invariably were quick to respond favorably to a request for use of time for broadcasts of programs sponsored by a local medical society, the State Association, or the American Medical Association, the great majority of such broadcasts being without compensation to the broadcasting company.

He pledged full cooperation with the medical profession in broadcasting so-called health programs.

Almost without exception, the speakers on the formal program, as well as those who participated in the roundtable discussion which followed, spoke out against every form of socialized medicine, socialism, and communism.

The AMA

Charles Armentrout, representing the Gazette, asked what the medical profession has to offer in place of socialized medicine, and this question resulted in a general discussion of the whole program of the State Medical Association and the American Medical Association in opposition to compulsory health insurance.

Larry Rember, of Chicago, public relations director of the American Medical Association, explained in detail the Association's 12-point program. He said that the organization feels that the extension of voluntary health insurance so as to provide protection for all of our people, especially those in the middle and lower income groups, is the real answer to the problem of providing medical and hospital services within the reach of all.

Mr. Rember, in answer to a question from the floor, said that the AMA's definition of socialized medicine is "federal control from Washington of all medical and surgical needs." He hastened to add that the AMA had not intended to lay down any cut and dried interpretation of socialized medicine with all state societies instructed to follow a particular pattern.

Roundtable Discussion

In the two-hour roundtable discussion, practically every topic concerned with medicine was discussed, including, besides socialized medicine, fees, ethics, medical education, and the shortage of doctors in West Virginia.

Doctor Holroyd said that the national average of physicians to population is one to every 700 persons, and Dr. N. H. Dyer, state director of health, who has just completed the registration of doctors of medicine in this state, reported that the average in West Virginia is one doctor to about 1400 persons.

It was brought out during the discussion that the medical profession in West Virginia favors the creation of a national department of health headed by a doctor of medicine, and that it is supporting the plan of the state health department to increase the number of full-time health units.

The matter of the handling of complaints against doctors was discussed in connection with the proposal of the Council of the State Medical Association to create a state grievance committee. This proposal will be submitted to the Association's House of Delegates for action at the annual meeting at White Sulphur Springs, July 27-29. However, it was explained by Dr. James S. Klumpp, of Huntington, member of the Council, that there is already in each local medical society a group which investigates individual claims of over-

Relman Morin

charging, malpractice, etc. If matters of this nature cannot be settled at the local level, they are referred to one of the twelve Councillors for study and report.

The doctor group present reaffirmed the stand of the profession on medical education, and it was stated that every effort is being made to obtain the creation of a four-year school of medicine and dentistry in West Virginia.

The conference adjourned at five o'clock for a social hour, after which those present were guests of the West Virginia State Medical Association at dinner.

Relman Morin Guest Speaker

Relman Morin, of New York City, general executive of the Associated Press, was the guest speaker at the dinner. His subject was, "Foreign Relations," and he reported vividly and in detail his experiences during world War II, recalling that he was interned by the Japanese in Saigon, Indo-China, the day after Pearl Harbor, charged with espionage because of his rovings as a press representative in the South Seas.

The speaker discounted the idea that there is any immediate threat of actual warfare with Russia or any other country. "This country," he said, "has worked itself into a state of unnecessary jitters." He does not think that Russia will have the support of its allies or satellites in the event of war.

Mr. Morin asserted his belief that there is no such thing as retention of secrets concerning the atom or hydrogen bombs. He inferred that the Germans knew about the A-bomb a week after its development in this country.

He stated that there is no reason to become alarmed about the Chinese situation. "The situation there," he said, "is no different than it was 20 years ago. The stage is the same; only the actors are different."

Mr. Morin said that he favored steps to put Japan back on her feet, believing that that country can become a bulwark of force in our favor in the East.

S. E. SURGICAL HONORS DR. E. L. GAGE

Dr. C. C. Howard, of Glasgow, Kentucky, was elected president of the Southeastern Surgical Congress at the annual meeting in Washington, D. C., March 6-9, 1950. He succeeds Dr. R. J. Wilkinson, of Huntington.

Dr. Joseph S. Stewart, of Miami, Florida, was named president elect, and Dr. J. Duffy Hancock, of Louisville, Kentucky, first vice president. Dr. B. T. Beasley, of Atlanta, Georgia, was reelected secretary-treasurer.

Dr. E. Lyle Gage, of Bluefield, former vice chairman of the West Virginia Section of the Congress, was named chairman by the new president, Doctor Howard, and also as a member of the Council from West Virginia. He succeeds Dr. R. K. Buford, of Charleston.

In his presidential address, Dr. R. J. Wilkinson called for an end to the treatment in veterans hospitals of veterans with non-service connected disabilities. He recommended that a large number of the hospitals be turned over to states and communities to help alleviate the acute shortage of beds.

Doctor Wilkinson's proposals were endorsed officially in a resolution adopted by the Congress.

More than 25 West Virginia surgeons attended the three-day meeting of the Congress in Washington.

WEST VIRGINIA WELL REPRESENTED AT ANNUAL MEETING OF AAGP IN ST. LOUIS

The second annual meeting of the American Academy of General Practice, held at St. Louis, February 20-23, 1950, drew a record number of more than 2600 doctors from all parts of the country. The overall registration was slightly in excess of five thousand, as compared with about 3500 at Cincinnati in 1949.

The cancellation of trains serving the west no doubt resulted in a smaller attendance of West Virginia doctors than would have been the case had trains been running on normal schedules. However, more doctors attended the St. Louis session this year than the first meeting at Cincinnati in 1949.

New Officers

Dr. Jason P. Sanders, of Shreveport, Louisiana, was named president elect of the academy. He will take office at the San Francisco meeting. Dr. D. G. Miller, Jr., of Morgantown, Kentucky, was elected vice president, and Dr. R. B. Robins, of Camden, Arkansas, speaker of the Congress of Delegates. Dr. Stanley R. Truman, of Oakland, California, succeeds Dr. Elmer C. Texter, of Detroit, Michigan, as president. He will serve until the annual meeting at San Francisco, March 19-22, 1951.

Scientific Program

The scientific program was unusually good. Dr. Philip Thorek, of Chicago, who will be one of the guest speakers at the annual meeting of the West Virginia State Medical Association, July 27-29, spoke before the scientific assembly on February 23. He was also a guest speaker at the meeting in Cincinnati in 1949. Another speaker on the program was Dr. Irving S. Wright, of Cornell University Medical College, who was a guest speaker at the 82nd annual meeting of the State Medical Association at White Sulphur Springs last year.

Still another speaker well-known to West Virginia doctors was Dr. C. Charles Burlingame, of Hartford, Connecticut, president and psychiatrist-in-chief of the Institute of Living. His subject was, "The Rule of Reason in Psychiatry."

In his address, Doctor Burlingame stated that the day of impersonal medical treatment is past. "Doctors," he said, "must know their patients because otherwise they are often producing neurotics and psychopaths who may end up in suicide."

Doctor Thorek, who is connected with the department of surgery of the University of Illinois, and the Cook County Graduate School of Medicine, said that diseases involving the abdomen present an interesting challenge to the "family doctor" and the surgeon. Based upon an examination of case charts at the Cook County Hospital, in Chicago, over a ten-year period, he said that six outstanding conditions were found which sometimes confuse a physician. These were acute appendicitis, inflammation of the gall bladder, perforated stomach ulcers, pancreatic hemorrhage, passage of a kidney stone, and coronary occlusion. He listed inflammation of the Fallopion tube as a seventh disease de-

serving special attention, because it is sometimes confused with gall bladder trouble.

Doctor Thorek warned that the general practitioner as well as the surgeon must be on his guard constantly to avoid "the fatal error of confusing an acute coronary disease with an acute abdominal condition."

Compulsory Health Insurance Opposed

Dr. R. B. Robins, of Camden, Arkansas, speaker of the Congress of Delegates, in attacking the proposed national compulsory health program, said that there was no crisis in the health of the nation that would provide the basis for so radical a proposal. He pointed out that over 65,000,000 Americans are already covered by hospital insurance and that of this total, forty million have insurance for surgical expense, and twenty million for medical care.

He urged doctors to be active in the fall election of 1950, and called this a "year of decision" for the medical profession. He said that the outcome of the election this year could very well mean whether the American doctor will remain free to continue practice or be forced to practice as the government might dictate.

5-Point Creed Suggested

Mac F. Cahal, executive secretary of the academy, suggested the following 5-point creed for family doctors: Both doctors and patients to remain free agents, unfettered by government control; medical care based on general practice with the public benefitting most if each family has a "family doctor"; medicine to remain a public trust; access to hospital facilities for every competent doctor; and a program of postgraduate work for every physician to help him keep abreast of scientific progress.

GP Sections in Hospitals Favored

The Congress of Delegates approved a resolution favoring the establishment of sections of general practice in staff organizations of major hospitals.

West Virginia Doctors Registered

Dr. James C. Repass, of Lumberport, and Dr. Thomas Blake, of St. Albans, delegates representing the West Virginia Academy of General Practice, and Dr. William P. Bradford, of Moundsville, and Dr. Halvard Wanger, of Shepherdstown, alternates, attended the meeting, together with Dr. J. L. Patterson, of Logan, the president, and Dr. Carl B. Hall, of Charleston, secretary-treasurer.

Other doctors from West Virginia registered at the meeting were J. Paul Aliff, Charleston; J. C. Arnett, Rowlesburg; William J. Bannen, Jr., Dunbar; T. Maxfield Barber, Charleston; H. George Bateman, Williamstown; B. V. Blagg, Charleston; Myer Bogarad, Weirton; Randall Connelly, Vienna; DelRoy R. Davis, Kingwood;

William S. Dick, Parkersburg; David L. Ealy, Moundsville; Orda M. Harper, Clendenin; Norris F. Hines, Huntington; L. I. Hoke, Nitro; Logan W. Hovis, Parkersburg; A. P. Hudgins, Charleston; Franklin B. Murphy, Philippi; Victor A. Politano, Milton;

James G. Ralston, Clarksburg; C. N. Slater, Clarksburg; S. B. Souleyret, Cabin Creek; Jack J. Stark, Belpre, Ohio; J. Edwin Stoechel, Charleston; Lucien M. Strawn, Morgantown; R. A. Updike, Montgomery; John L. Van Metre, Charles Town; and Edwin O. Vaughan, St. Albans.

DIABETES GROUP TO ORGANIZE IN JULY

Plans for the formation of the State Diabetes Association are progressing nicely, and there is no doubt that the group will formally organize during the annual meeting of the West Virginia State Medical Association at White Sulphur Springs, July 27-29.

It has been announced by the diabetes committee that every physician in the state who is interested in diabetes is eligible to become a member of the organization. The association is being set up in a manner similar to that used in the organization of the West Virginia Heart Association several years ago.

The objects and purposes of the new association will be to sponsor an annual meeting, with a selected scientific program; disseminate information throughout the year on the subject of diabetes; and sponsor, with the West Virginia State Medical Association, an annual camp for diabetic children.

The committee is urging all doctors interested in the organization of the new association to be present at the White Sulphur meeting in July. At that time, a constitution and by-laws will be presented for adoption. Doctors who desire to become members are requested to write to the Diabetes Committee, care West Virginia State Medical Association, Box 1031, Charleston.

ACAD. OPH. AND OTOL. AT THE GREENBRIER

The 3rd annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held at the Greenbrier, in White Sulphur Springs, May 7-9, 1950, conjointly with the Virginia Society of Ophthalmology and Otolaryngology. An interesting program is being arranged by the two groups, and reservations for the meeting are now being accepted by the management at the Greenbrier.

Dr. Garnett P. Morison, of Charlestown, is president of the West Virginia Academy, and the other officers are as follows: First vice president, Dr. Charles T. St. Clair, Jr., Bluefield; second vice president, Dr. Arthur C. Chandler, Charleston; secretary, Dr. Melvin W. McGhee, Huntington; treasurer, Dr. Frederick C. Reel, Charleston; and directors, Drs. Eugene C. Hartman, Parkersburg, and Ivan Fawcett, Wheeling.

RELOCATIONS

Dr. Paul Gotses, of Fairmont, has accepted a residency in general surgery at Fort Howard Veterans Hospital, in Baltimore. His address is 3229 Texas Avenue, Parkeville, Baltimore 14, Maryland. Upon the completion of his residency he expects to return to Fairmont to resume the practice of his specialty of surgery.

* * * *

Dr. Glenn F. Palmer, of Pine Grove, has moved to Fayetteville, Arkansas, where he has accepted appointment as chief of the orthopedic service at the veterans hospital in that city.

ALLEGHANY-BATH AND GREENBRIER SPONSOR INTERESTING MEETING

An interesting scientific program has been arranged for an interstate medical meeting which is being held at the Greenbrier, White Sulphur Springs, March 29, sponsored jointly by the Alleghany-Bath Medical Society (Virginia) and the Greenbrier Valley Medical Society.

Dr. Chester S. Keefer, of Boston, is scheduled to open the program at 2:00 o'clock, with a paper on "Developments in Antibiotic Therapy." Other speakers on the afternoon program are as follows:

Russell L. Cecil, M. D., New York—"Diagnosis and Treatment of Arthritis, with Particular Reference to Cortisone and ACTH".

Frederick A. Coller, M. D., Ann Arbor—"The Use and Abuse of Parenteral Fluids in Surgical Patients".

Henry M. Thomas, Jr., M. D., Baltimore—"The Nervous Patient".

The evening program is scheduled to begin at 8:00 o'clock, and will include addresses as follows:

Marion A. Blankenhorn, M. D., Cincinnati—"The Specificity of the Vitamins and Their Proper Clinical Use".

Harvey B. Stone, M. D., Baltimore—"Nonmalignant Surgical Conditions of the Large Bowel".

No registration fee is being charged, and it is expected that there will be a large attendance of doctors from Virginia and West Virginia. Rooms are available at the Greenbrier and other hotels in White Sulphur Springs for those who expect to remain overnight in that city.

GREENBRIER CLINIC COUNCIL MEETS

The annual meeting of the advisory council of the Greenbrier Clinic, White Sulphur Springs, is being held as this issue of the Journal is on the press (March 29). The session, which is being held concurrently with an interstate meeting sponsored jointly by the Alleghany-Bath Medical Society (Virginia) and the Greenbrier Valley Medical Society, will probably end April 1.

Leaders from industry are meeting with the board, and discussions of mutual problems and responsibilities of medicine and industry have been scheduled. Guests from industry participating in the discussions include Arthur M. Hill, Washington, D. C.; Thomas Spates, New York City; James M. Francis, Huntington; Warren Draper, M. D., Washington; and Walter Tuohy, Cleveland.

Dr. Russell M. Haden, of Cleveland, is chairman of the advisory council. Drs. Walter E. Vest and R. J. Wilkinson, of Huntington, are members of the council.

A.M. ACAD. NEUROLOGY AT CINCINNATI

The first interim meeting of the American Academy of Neurology will be held in Cincinnati, April 14-15, 1950, in conjunction with the American Chapter of the International League Against Epilepsy. The two societies are sponsoring a symposium on psychomotor epilepsy on April 15.

FOUR-STATE MEETING OF SURGICAL GROUP

A joint meeting of four state sections of the Southeastern Surgical Congress has been arranged for July 13-15, 1950, at the Greenbrier, in White Sulphur Springs. The meeting will be sponsored jointly by the sections in the District of Columbia, Maryland, Virginia, and West Virginia.

Arrangements for the three-day meetings are being completed by a committee composed of Drs. W. Raymond MacKenzie, of Baltimore; Waverly R. Payne, of Newport News; E. L. Gage, of Bluefield; and Mr. R. J. Wilkinson, Jr., of Huntington, secretary of the West Virginia Section.

The program will include addresses by Doctor MacKenzie and Hon. Rush D. Holt, former United States Senator from West Virginia and now a member of the West Virginia House of Delegates. He will deliver the principal address at the banquet, his subject being, "The Fable of the Free Lunch."

Dr. Andrew E. Amick, of Lewisburg, past president of the West Virginia State Medical Association, and now a member of the Council of the Southern Medical Association, will deliver the address of welcome.

NBME NAMES ASSOCIATE SECRETARY

Dr. John P. Hubbard, Director of the Committee for the Improvement of Child Health of the American Academy of Pediatrics, has accepted appointment as associate secretary on the executive staff of the National Board of Medical Examiners, Philadelphia. Mr. Everett S. Elwood is the executive secretary and treasurer.

Doctor Hubbard has made numerous contributions to medical literature on subjects concerning pediatric cardiology and rheumatic fever, and pediatric public health. During World War II, he spent two years overseas attached to the Supreme Headquarters A. E. F. Military Government Public Health, with the rank of Colonel.

Since the war, his work has been chiefly with the American Academy of Pediatrics. He was director of the Academy's study of Child Health Services, 1945-48 (this study received the Lasker Award in 1949).

Doctor Hubbard will continue on a part-time basis his position on the faculty of the University of Pennsylvania, and will on April 1 assume his duties there as Professor of Public Health and Preventive Medicine.

PENNSYLVANIA EENT GROUP TO MEET

The annual meeting of the Pennsylvania Academy of Ophthalmology and Otolaryngology will be held May 12-14, 1950, at the Bedford Springs Hotel, Bedford, Pennsylvania. Speakers will include Drs. Edward H. Campbell, Frank D. Costenbader, Karl M. Houser, Raymond E. Jordan, John E. L. Keyes, Francis L. Lederer, Irving H. Leopold, Maurice Saltzman, Richard G. Scobee, Edmund B. Spaeth, and Frank B. Walsh.

Twelve Study groups will be conducted, and they will run consecutively with the scientific sessions.

Further information concerning the program may be obtained by writing to Dr. B. F. Souders, Secretary, 143 N. Sixth Street, Reading, Pennsylvania.

ANNUAL AUDIT

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1949 has been completed by Norman S. Fitzhugh & Company, Certified Public Accountants, and submitted to the Association's treasurer, Dr. T. Maxfield Barber, of Charleston.

The complete audit, with letter of transmittal, follows:

NORMAN S. FITZHUGH & COMPANY
Public Accountants
Kanawha Banking & Trust Building
Charleston 1, W. Va.

Dr. T. M. Barber, Treasurer
West Virginia State Medical Association
Charleston, West Virginia

We have audited the receipts and disbursements of West Virginia State Medical Association for the calendar year ended December 31, 1949, and submit herewith statements of the various funds for the year under review.

All receipts of record and all disbursements were verified and the cash balance of $24,997.95 at December 31, 1949, was reconciled with the statement of the depository bank. Cancelled checks evidencing all disbursements for the year were on hand except for two outstanding checks aggregating $12.50.

The subsidiary records were test checked to the extent we deemed adequate to satisfy ourselves that the receipts of record have been properly accounted for.

United States Treasury 2% Bonds registered in the name of the Association and having a face value of $22,000.00 were inspected by us at your safe deposit box on March 7, 1950.

A comparative statement of assets and balances in the various funds at the close of 1948 and 1949 is as follows:

	12-31-48	12-31-49	Increase (Decrease)
General Fund	$ 4,232.86	$ 3,514.85	($ 718.01)
Public Relations Fund		16,823.52	16,823.52
Medical Journal Fund	6,405.53	7,730.91	1,325.38
Convention Fund (Deficit)	(2,139.86)	(3,071.33)	(931.47)
Cash in Bank	8,498.53	24,997.95	16,499.42
U. S. Treasury 2% Bonds (Face Value $22,000.00) at Cost	22,101.53	22,101.53	
Total Assets	$30,600.06	$47,099.48	$16,499.42

In our opinion, all receipts of record and disbursements for the calendar year 1949 have been properly accounted for and are correctly stated on the books of the Association and in the statements attached hereto.

NORMAN S. FITZHUGH & COMPANY
By Norman S. Fitzhugh, Jr.,
Certified Public Accountant.

Charleston, W. Va.
March 10, 1950.

COMBINED STATEMENT OF RECEIPTS AND DISBURSEMENTS

Calendar Year 1949

BALANCE—JANUARY 1, 1949			$8,498.53
RECEIPTS:			
Dues (net)		$19,567.50	
Interest on U. S. Bonds		440.00	
Public Relations Assessments:			
A. M. A.	$22,800.00		
State	21,035.00	43,835.00	
Advertising		16,842.69	
Emblems Sold		201.00	
Subscriptions to Journal		143.82	
Advance Registration Fees (net)		3,184.37	
Commercial Exhibits		75.00	
Contributions—Convention Entertainment		310.00	
Total Receipts			84,599.38
			93,097.91
DISBURSEMENTS:			
General Fund		20,725.51	
Public Relations Fund:			
A. M. A. Assessments	$22,400.00		
State Expenses	4,611.48	27,011.48	
Medical Journal Fund		15,862.13	
Convention Fund		4,500.84	
Total Disbursements			68,099.96
BALANCE—DECEMBER 31, 1949			$24,997.95

Cash in Bank December 31, 1949 — $24,997.95

GENERAL FUND

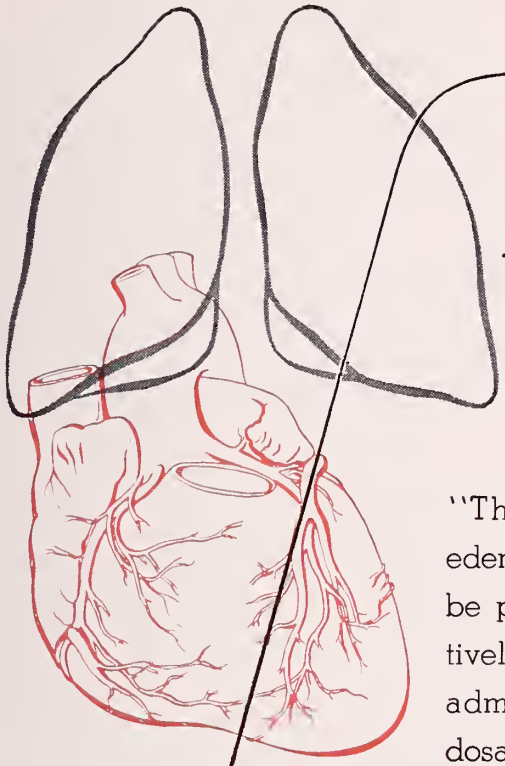
Statement of Receipts and Disbursements Calendar Year 1949

BALANCE—JANUARY 1, 1949			$4,232.86
RECEIPTS:			
Dues	$19,582.50		
Less—Refunds	15.00	$19,567.50	
Interest on U. S. Bonds		440.00	
Total Receipts			20,007.50
			24,240.36
DISBURSEMENTS:			
Salary—Executive Secretary (less payroll taxes)		6,232.90	
Office Salaries (less payroll taxes)		4,222.67	
Office Supplies and Expense		770.62	
Office Rent		1,500.00	
Telephone and Telegraph		446.00	
Postage		422.00	
Travel		1,848.36	
Miscellaneous Expense		1,498.29	
Social Security		161.22	
Secretary's Conference Expense		461.55	
Withholding Tax		1,782.15	
Mimeographing		632.52	
Expense of Meetings—Council and Association Committees		747.23	
Total Disbursements			20,725.51
BALANCE—DECEMBER 31, 1949			$3,514.85

PUBLIC RELATIONS FUND

Statement of Receipts and Disbursements Calendar Year 1949

NATIONAL ASSESSMENTS			
Assessments—1949		$22,800.00	
Less: Payments to A. M. A.		22,400.00	
Balance due A. M. A.			$ 400.00
STATE ASSESSMENTS			
Assessments—1949		21,035.00	
Less: Conference and General Expense		4,611.48	
Balance in State Fund			16,423.52
BALANCE—DECEMBER 31, 1949			$16,823.52



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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Barach, A. L.: Edema of the Lungs, Am. Pract. 3:27 (Sept.) 1948.

MEDICAL JOURNAL FUND

Statement of Receipts and Disbursements
Calendar Year 1949

BALANCE—JANUARY 1, 1949		$ 6,405.53
RECEIPTS:		
Advertising	$16,842.69	
Emblems Sold	201.00	
Subscriptions to Journal	143.82	
Total Receipts		17,187.51
		23,593.04
DISBURSEMENTS:		
Salaries—Executive Secretary	2,400.00	
Office Salaries	550.00	
Printing	11,491.96	
Engraving	250.63	
Postage	210.00	
Emblems & Frames Purchased	300.00	
Miscellaneous Expense	659.54	
Total Disbursements		15,862.13
BALANCE—DECEMBER 31, 1949		$ 7,730.91

CONVENTION FUND

Statement of Receipts and Disbursements
Calendar Year 1949

BALANCE (Deficit)—January 1, 1949				(2,139.86)
RECEIPTS:				
Advance Registration Fees	$3,420.00			
Less—Refund of Fees	235.63	$3,184.37		
Commercial Exhibits			75.00	
Contributions—Convention Entertainment			310.00	
Total Receipts				3,569.37
				1,429.51
DISBURSEMENTS:				
Entertainment		2,030.81		
Less—Special Contribution		250.00	1,780.81	
Travel			1,413.94	
Supplies and Labor			950.73	
Reporting			174.90	
Miscellaneous Expense			180.46	
Total Disbursements				4,500.84
BALANCE (Deficit)—DECEMBER 31, 1949				($3,071.33)

STATE PUBLIC HEALTH SERVICES

Today we have seven full-time county health departments with full-time health officers. We have ten county health departments with part-time health officers. Seventeen counties are in district health departments under the direction of full-time health officers while eleven counties are in district health departments served by part-time health officers. Five counties have nursing service only and four counties are served by sanitarians only. One county has no public health services whatsoever.—N. H. Dyer, M. D., State Director of Health, in Health News.

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A. F. FORTUNE, M. D., MEDICAL DIRECTOR BEN F. FORTUNE, M. D., ASSOCIATE MEDICAL DIRECTOR

OBITUARIES

HARVEY MONTREVILLE ANDREW, M. D.

Dr. Harvey Montreville Andrew, 63, of Weston, died suddenly March 10, 1950, while preparing to give a blood transfusion at a hospital in that city. Death was attributed to a heart attack.

Doctor Andrew was born near Waynesburg, Pennsylvania, son of C. H. and Matilda Belle Andrew. He attended Waynesburg college, and received his M. D. degree from John Hopkins University School of Medicine, Baltimore, in 1915. After practicing in Connecticut, he moved to Weston in 1929, where he continued in active practice continuously until his death.

He was a member of the Central West Virginia Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Besides his widow, the former Virginia Ballard, he is survived by two children, Kathryn and John, all of Weston; a brother, Carter Andrew, of Nineveh, Pennsylvania; and three sisters, Mrs. Harper Mannon, of Prosperity, Pennsylvania; Mrs. Clement Ladd, of Sunbury, Pennsylvania; and Mrs. H. S. Day, of Pittsburgh.

* * * *

LEE OTIS HILL, M. D.

Dr. Lee Otis Hill, 69, of Camden-on-Gauley, died in his sleep at his home in that city, February 26, 1950. He had not been previously ill, and was active in practice until his death.

Doctor Hill was born at Hookersville, West Virginia, and received his academic education at Marshall College. He received his M. D. degree from the College of Physicians and Surgeons, Baltimore, in 1905.

Doctor Hill was an honorary member of the Central West Virginia Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Besides his widow, he is survived by a son Dr. George D. Hill, of Camden-on-Gauley, and two sisters, Mrs. Viola Harold, of Cowen, and Mrs. Minta Gardner, of Huntington.

* * * *

ROBERT HAROLD JONES, M. D.

Dr. Robert Harold Jones, 47, of Fairmont, died March 2, 1950, in a hospital at Pittsburgh, following a brief illness.

Doctor Jones received his M. D. degree in 1933 from the Medical College of Virginia, Richmond. He located at Montgomery, and accepted appointment on the medical staff at Laird Memorial hospital, where he remained until 1941, when he moved to Fairmont.

Doctor Jones served overseas with the 106th Station Hospital during World War II. He was separated from the service in January, 1946, with the rank of lieutenant colonel.

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RADAR DIATHERMY

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- A high degree of absorption.
- Penetrating energy for deep heating.
- A desirable temperature ratio of fat to vascular tissue.
- Effective production of active hyperemia.
- Desirable relationship between cutaneous and muscle temperature.
- Controlled application over large or small areas.
- Elimination of electrodes, pads and danger of arcs.

POWERS & ANDERSON

W. Va. Representative
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2 South Fifth St.
Richmond, Virginia

He is survived by his widow and a daughter. He is also survived by his parents who reside at Orlando, Florida.

* * * *

LABAN PHELPS STANLEY, M. D.

Dr. Laban Phelps Stanley, 47, of Charleston, plant physician for Carbide and Carbon Chemicals Corporation, South Charleston, died March 2, 1950, in Huntington, following a heart attack.

Doctor Stanley was born at Bedford, Kentucky, son of the late I. T. and Lena H. Stanley. He was graduated from West Virginia University in 1926 with the degree of B. S., and received his M. D. degree at the University of Louisville School of Medicine in 1928. He was licensed to practice in West Virginia in 1929, and was engaged in general practice at Pine Grove before moving to Charleston in 1943.

Doctor Stanley was a member of Kanawha Medical Society, the West Virginia State Medical Association, the American Medical Association, the Southern Medical Association, and the American Association of Industrial Physicians and Surgeons.

Besides his widow, he is survived by a son, Robert Phelps Stanley, a student at West Virginia University, in Morgantown, and a daughter, Mary Suzanne, of Charleston.

* * * *

ROY BEN MILLER, M. D.

Dr. Roy Ben Miller, 72, of Parkersburg, a past president of the West Virginia State Medical Association, died at his home in that city March 18, 1950. He had been in ill health for several months.

Doctor Miller was born at Asbury in Greenbrier county, son of the late John A. and Sarah (Knapp) Miller. He received his early education in the public schools in Greenbrier county, and was graduated from the Medical College of Virginia in Richmond, in 1903. He was licensed to practice medicine in West Virginia in 1902.

After serving his internship and a residency at the Memorial Hospital, in Richmond, he located at Hinton in 1906, where he engaged in practice until 1915. He moved to Parkersburg that year and remained in the active practice of his specialty of surgery until 1947, when he was compelled to retire on account of ill health.

Doctor Miller was a past president of the Parkersburg Academy of Medicine, and served in 1934 as president of the West Virginia State Medical Association. Previously he had served as a member of the Council for four years. He had been a member of the Parkersburg Academy of Medicine, the West Virginia State Medical Association and the American Medical Association since 1909. He had held honorary membership in all three organizations since 1943.

Besides his widow, he is survived by a brother, Amos Miller, of Radford, Virginia.

Freedom from want, if interpreted as freedom from the necessity to struggle, would be a calamity if ever realized.—Walter H. Judd.

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COUNTY SOCIETIES

BOONE

Dr. John C. Condry, of Charleston, was the guest speaker at the February meeting of the Boone County Medical Society, held at the Madison General Hospital, in Madison. His subject was, "Sympathectomy for Perepheral Vascular Disease."

Dr. Charles E. Watkins, of Oak Hill, president of the West Virginia State Medical Association, and Charles Lively, of Charleston, executive secretary, were guest speakers at the January meeting of the Boone County Medical Society. They discussed national and state medical public relations and proposed legislation.

At the business meeting following the speaking program, the following officers were elected for the new year: president, Dr. W. F. Harless; vice president, Dr. O. D. McCallum; secretary-treasurer, Dr. Ray I. Frame; and chairman of the PR committee, Dr. H. H. Howell.

Drs. H. A. Smith and Ray I. Frame were elected delegates to the House of Delegates, and Drs. Wyson Curry, Jr., and O. D. Ballard were named alternates.—Ray I. Frame, M. D., Secretary.

* * * *

CABELL

Dr. J. H. Foulger, of Wilmington, Delaware, director of medical research for E. I. du Pont de Nemours Company, and director of the Haskell Laboratories in that city, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society, held March 9, 1950, in the club house of the Owens-Illinois Glass Company plant at Huntington. He presented an interesting paper on "The Challenge of Industrial Medicine."

At the business meeting following the scientific program, Dr. I. W. Taylor was elected to honorary membership, and Dr. Robert W. Hibbard, a member of the medical staff of the Huntington State Hospital, was elected to membership in the society.

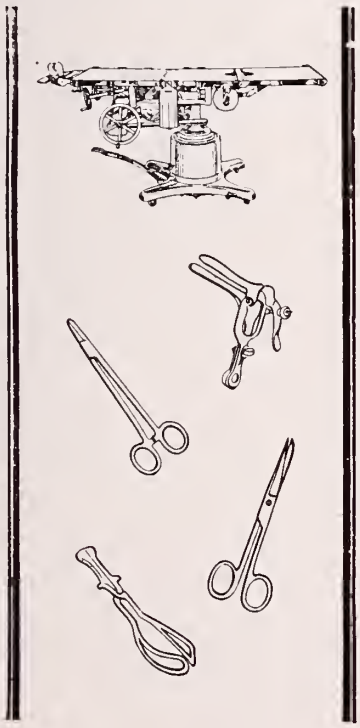
At the close of the meeting, refreshments were served by the Owens-Illinois Glass Company.—James A. Heckman, M. D., Secretary.

* * * *

FORT HENRY ACADEMY

Dr. Stewart H. Clifford, chief of premature service at the Children's Hospital, and assistant pediatrician at Harvard Medical School, Boston, was the guest speaker at the January meeting of the Fort Henry Academy of Medicine, in Wheeling. His subject was, "Modern Care of the Newborn (Full Term and Premature)." There was a record attendance at the meeting, and guests included nurses from all of the Wheeling area hospitals.

At the February meeting of the Academy, Dr. Temple Fay, of Philadelphia, was the guest speaker. His subject was, "Diagnostic Screening Problems in Cerebral



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Palsy." The meeting was attended by over 100 members and guests.—Robert M. Sonneborn, M. D., Secretary.

* * * *

HARRISON

No business or scientific program was arranged for the Harrison County Medical Society for the month of March. Instead, the members of the Society, with their wives, were present at a Doctor's Day dinner and dance, held March 4, at the Clarksburg Country Club.—L. D. Zinn, M. D., Secretary.

* * * *

KANAWHA

Dr. James B. Funkhouser, assistant chief of the neuropsychiatric service at McGuire General Hospital, Richmond, Virginia, was the guest speaker at the regular monthly meeting of the Kanawha County Medical Society, held March 14, at the Daniel Boone Hotel, in Charleston. His subject was, "Psychiatric Aspects of Epilepsy."

At the business meeting following the scientific program, Drs. Joseph J. Claro, of Clendenin, and Leon Herman, of Widen, were elected to membership in the society.—Robert C. Bock, M. D., Secretary.

* * * *

MERCER

Dr. Charles E. Watkins, of Oak Hill, president of the West Virginia State Medical Association, was the guest speaker at the regular monthly dinner meeting of the Mercer County Medical Society, held February 20, at Pete's Grill, in Bluefield. He discussed the Association's program for the coming year.

At the business meeting following the scientific program, Dr. E. L. Gage, Councillor from the Fifth District, was directed to present to the Council at the next meeting a proposal that the State Medical Association cooperate with the State Department of Health, the West Virginia Tuberculosis and Health Association, the West Virginia Heart Association, and the West Virginia Cancer Society in sponsoring a health exhibit at the annual State Fair, to be held in Greenbrier county in the fall of 1950.

Dr. Richard C. Neale, in discussing the membership of the State Board of Health, stated that the medical profession has but three members on the Board, one of whom is not a member of the State Medical Association. The feeling was expressed that all three medical members of the State Board should be members of the State Medical Association. Doctor Gage was directed to present this matter to the Council, and the secretary was instructed to write to Governor Okey L. Patteson expressing the feelings of the Society in the matter.—Frank J. Holroyd, M. D., Secretary.

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MINGO

The regular monthly dinner meeting of the Mingo County Medical Society was held February 16, in the King Cole Room at the Mountaineer Hotel, in Williamson.

Two sound movies, "Management of the Failing Heart," and "Congenital Cardiovascular Anomalies Amenable to Surgery," were shown, and a series of records on "Stethoscopic Heart Sounds" were played.

The following doctors were elected to membership in the Society: Harry Ison, Red Jacket; W. J. Smith, Belfry, Kentucky; and N. W. Staker and Joseph Donovan, both of Delbarton.

Dr. E. P. Stepp, of Kermit, presided at the meeting in the absence of the president, Dr. J. C. Lawson.—E. T. Drake, M. D., Secretary.

* * * *

OHIO

At a meeting of the Ohio County Medical Society, held March 6, in Wheeling, it was ordered that the payment of AMA dues of $25.00 for 1950 be a prerequisite to membership in the Society.

Drs. Robert O. Strauch and John Paul Young, both of Wheeling, were elected members of the Society, and Dr. Helen M. Wiestling, also of Wheeling, was elected to membership by transfer from the Massachusetts Medical Society.—W. Carroll Boggs, Secretary.

WOMAN'S AUXILIARY

KANAWHA

Mr. Charles Sattler, of Charleston, West Virginia Commissioner of Labor, was the guest speaker at the regular monthly luncheon meeting of the Woman's Auxiliary to Kanawha Medical Society, held March 14, 1950, at the Ruffner Hotel, in Charleston. His address was in the nature of a report, with comments, on a recent trip overseas, which included a visit to England. He was a delegate from the United States to a meeting of the International Labor Office at Geneva, Switzerland.

Mr. Sattler spoke freely and frankly concerning the general situation in England, emphasizing the apparent lack of adequate medical and hospital service. "The extremes to which the British people have gone in socialized medicine," he said, "parallels the extremes to which they have gone in the nationalization of industries." Continuing, the speaker warned that it is not only important that we avoid the extremes to which the British people have gone, notwithstanding the fact that they are actually more conservative than we, but that it is equally important that we correct or avoid the conditions, the practices and policies which

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Surgery of Colon & Rectum, One Week, starting April 10, May 15.
Esophageal Surgery, One Week, starting June 5.
Breast & Thyroid Surgery, One Week, starting June 26.
Thoracic Surgery, One Week, starting June 12.
Gallbladder Surgery, Ten Hours, starting April 24.
Fractures & Traumatic Surgery, Two Weeks, starting June 12.
Basic Principles in General Surgery, Two Weeks, starting September 11.
GYNECOLOGY—Intensive Course, Two Weeks, starting April 17, June 19.
Vaginal Approach to Pelvic Surgery, One Week, starting May 15.
OBSTETRICS—Intensive Course, Two Weeks, starting April 3, June 5.
PEDIATRICS—Intensive Course, Two Weeks, starting April 3.
Personal Course in Cerebral Palsy, Two Weeks, starting July 31.
Personal Course in Diagnosis & Treatment of Congenital Malformations of the Heart, Two Weeks, starting June 5.
MEDICINE—Intensive General Course, Two Weeks, starting April 24.
Electrocardiography & Heart Disease, Two Weeks, starting July 17.
Hematology, One Week, starting May 8.
Gastro-enterology, Two Weeks, starting May 15.
Liver & Biliary Diseases, One Week, starting June 5.
Gastroscopy, Two Weeks, starting May 15, June 12.
DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.
UROLOGY—Intensive Course, Two Weeks, starting April 17.
Cystoscopy, Ten Day Practical Course, every two weeks.

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constitute the underlying cause of this extreme action on their part.

The speaker made it plain that he sincerely believes in the free enterprise system to which we are committed, whether it be in the field of industry or medicine. "Such a system," he said, "has definite responsibilities and obligations which must be fulfilled to avoid endangering the whole system."

He discussed the present plight of the doctor in England, as well as his patients. He stated that the offices of doctors are filled with patients with every sort of imaginable ills, while those who are really sick "find it difficult to secure the attention they require."

Mr. Sattler quoted from the presidential address of Dr. R. J. Wilkinson before the recent meeting of the Southeastern Surgical Congress in Washington, and stated that he is in full accord with his recommendations that some method be devised to provide the low-income family with medical and hospital service. "I feel," he said, "that there is a real danger in the United States because these things about which I have spoken have happened in other countries, and if we refuse to recognize the need for the correction of abuses, then they might happen here."

Praising the efforts of the overwhelming majority of doctors who try to do what is right, Mr. Sattler said that "you don't hear about the hundreds of doctors who are doing a great work for the whole people, but you do hear about the one doctor who may do something that is not right." He urged that the doctors themselves make an effort to ascertain whether or not criticism leveled at the profession is justified.

Mrs. William A. Thornhill, the president, presided at the luncheon, which was attended by more than 90 members and guests. Mrs. Joel Allen, Auxiliary public relations chairman, introduced the speaker.

Mrs. Thornhill announced that a total of over $250.00 had been realized from the benefit bridges recently given at the homes of several of the members for the benefit of the Nurse Recruitment Scholarship Fund.

Guests at the luncheon included Dr. V. L. Peterson, vice president of Kanawha Medical Society; Drs. F. C. Reel and C. F. Lewis, members of the advisory board; Dr. John W. Hash, representing Kanawha Medical Society's public relations committee; and Mr. Charles Lively, executive secretary of the West Virginia State Medical Association.

Guests were also present from the following lay organizations: Kanawha County Education Association, American Association of University Women, Eastern Star, League of Women Voters, West Side Woman's Club, Pilot Club, Quota Club, YWCA, Charleston Woman's Club, and Kanawha County PTA.—Mrs. V. L. Peterson, Secretary.

* * * *

McDOWELL

Mrs. Eva Counts, executive secretary of the Mercer County Tuberculosis Association, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the McDowell County Medical Society held February 8 in the Appalachian Community Room, at Welch. Mrs. Counts' subject was "Adoption Plans and Reeducation in Tuberculosis."

A tea followed the presentation of the program.—Mrs. Ray E. Burger, Secretary.

* * * *

MERCER

Dr. Frank J. Holroyd, of Princeton, chairman of the public relations committee of the West Virginia State Medical Association, was the guest speaker at a luncheon meeting of the Woman's Auxiliary to the Mercer County Medical Society, held March 14, at Pete's Grill, in Bluefield.

The speaker urged that additional work be done by the members in obtaining the adoption by organizations and groups of resolutions opposing compulsory health insurance. He stressed the danger of the passage by Congress of any bill concerned with the socialization of medicine, and urged that the members familiarize themselves with the real meaning of socialism.

Doctor Holroyd also spoke of voting intelligently in the next election and asked that the members study the plans that are developing in other states to fight socialism.

Dr. Ben Bird, also of Princeton, chairman of the PR committee of the Mercer County Medical Society, reported concerning the progress that has been made in the cities and towns of Mercer county in educating the people to the danger of regimentation.

The Auxiliary's present project is work in aiding in the prevention and control of tuberculosis, and members are serving at the tuberculosis clinic which is held each second Tuesday at the court house, in Princeton.

Each member was presented with a copy of the new yearbook, which was prepared by Mrs. D. V. Kechele.

Hostesses for the luncheon meeting were Mrs. Ben Bird, of Princeton, and Mrs. C. M. Flynn, of Bluefield. Mrs. R. S. Gatherum, Jr., of Bluefield, served as program chairman.—Mrs. Fred S. Richmond, Corresponding Secretary.

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PARKERSBURG ACADEMY

Mrs. John Snyder, of Parkersburg, Psychologist for the Behaviour Clinic, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Parkersburg Academy of Medicine, held in that city, February 14. Her subject was "What is a Problem Child?" and she discussed specifically (a) persistence of behaviour, (b) importance of knowing whether a problem child will respond to behaviour course methods of handling, and (c) whether child's behaviour seems logical and appropriate.

The speaker discussed generally the operation of the clinic which is sponsored by the Parkersburg Junior League.

The Auxiliary completed plans for a display in the McKinley pharmacy window in keeping with the annual Red Cross membership drive in March. Mrs. Logan W. Hovis will serve as chairman, and she will be assisted by Mrs. Richard Corbitt.

Mrs. Fred Potter announced that plans had been completed for the annual Student Nurses' Fund benefit dance, which will be held in the Elks Club Ballroom, April 30.

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Hostesses were mesdames E. C. Hartman, Milton A. Gilmore, B. B. Nicholson, and E. W. Crooks.

Dr. Thomas L. Harris, of Parkersburg, was the guest speaker at the regular luncheon meeting of the Woman's Auxiliary to the Academy of Medicine of Parkersburg, held March 14, in the Blennerhassett room of the Chancellor Hotel, in Parkersburg.

Doctor Harris, who was introduced by the president, Mrs. M. A. Santer, discussed the cancer control program, with particular emphasis upon the establishment of an information center in Parkersburg. He stressed the need for the united support of the people of his home city in the project.

The local cancer information center has been opened at 603½ Market Street, and Doctor Harris called for the fullest support and cooperation of all groups and individuals in the annual drive for funds sponsored by the West Virginia Cancer Society and the American Cancer Society.

Mrs. Dana T. Moore, president of the Woman's Auxiliary to the West Virginia State Medical Association, discussed the work of the state organization in connection with efforts that are being made to control the disease. Mrs. John Gile was named Auxiliary chairman for this special work among the members.

The following nominating committee was named by the president: Mrs. A. M. Dearman, Mrs. Athey Lutz, Mrs. William Dick, and Mrs. Ray Wharton, alternate. The committee is to report at the April meeting.

Hostesses for the luncheon meeting were mesdames W. W. Davis, F. L. Blair, A. M. Dearman, and James C. Batten.—Mrs. Paul L. McCuskey, Corresponding Secretary.

* * * *

RALEIGH

Dr. Charles E. Watkins, of Oak Hill, president of the West Virginia State Medical Association, and Dr. Paul E. Vaughan, of Beckley, were guest speakers at the regular monthly luncheon meeting of the Woman's Auxiliary to the Raleigh County Medical Society, held February 27, at the Beckley Hotel, in Beckley.

Mr. R. E. Hinckley sang several selections, and he was accompanied by Mrs. H. A. Sloan.

At the business meeting held following the entertainment program, donations were ordered made to the March of Dimes and to the Pinecrest Fund.

Mrs. R. P. Daniel, president, presided at the meeting which was attended by 27 members and 3 guests, one of whom was Mrs. Charles E. Watkins, of Oak Hill. —Mrs. L. M. Halloran, Secretary.

* * * *

TAYLOR

At the organization meeting of the Woman's Auxiliary to the Taylor County Medical Society, held recently at Grafton, the following officers were elected: President, Mrs. Paul P. Warden; vice president, Mrs. Charles Haislip; and secretary-treasurer, Mrs. R. D. Stout.—Mrs. R. D. Stout, Secretary-Treasurer.

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ATOMIC DEFENSE

The Hiroshima bomb devastated 4 square miles, killed about 60,000 people, and injured some 69,000; the Nagasaki bomb blew up 1½ square miles, killed 39,000, and injured 25,000.

Pearse and Payne estimate that at Hiroshima there were probably 34,000 severely burned casualties, and calculate that to cope with this number of burns 170,000 "professional persons" (doctors, nurses, technicians) would be needed, eight thousand tons of medical supplies (enough to fill a Liberty ship) would be used, and the cost would be about 10 million dollars. And all this is for only one aspect of treatment.

Perrin Long believes that the explosion of a single bomb of the Hiroshima type would create within the first twenty-four hours the need for 300 first-aid teams, 500 stretcher-bearer teams, 400 casualty-collection points, and 24 neuropsychiatric centres. No wonder Park says that it is probably impossible to handle all the cases; we can only try to save some. And these grim estimates apply only to the original atomic-bomb explosions. Bombs capable of causing ten times this destruction are reputed to be a practical possibility, if not already made; and the proposed hydrogen bomb is said to be many times more powerful and destructive than even these.

Will any defense system be able to do more than rescue those at the fringe of the affected area? And if both sides in a war use these engines of obliteration, who will call himself the victor? It is of course suggested that fear of retaliation may prevent resort to atomic bombs and biological warfare. But those who start wars are prepared to take risks; and it is as well that everyone should realize what is involved in the "atomic defense" of which some politicians speak so glibly.—The Lancet.

NUTRITIVE VALUE OF FATS

With respect to the relative nutrition merits of the various types of food fats, a possibility exists that a certain fraction of milk fat may be more growth stimulating than the entire fat itself, although the consensus among nutrition investigators seems to be that the common animal and vegetable fats are just about equal in overall nutritive value.—Ruth Woods in Borden's Review of Nutrition Research.

IS YOUR WHEAT GOOD?

An old Negro farmer was asked by an evangelist what denomination be belonged to. He replied: "Bless you, sir, there's three roads leading from here to town—the long road, the shore road, and the swamp road—but when I go to town with a load of grain they don't say to me, 'Uncle Calhoun, which road did you come by?' but 'Cal, is your wheat good?' "—Anon.

Seven out of every 100,000 children will have cerebral palsy. Two of the seven will profit from an intensive treatment program, four will be unable to profit, and one will not need such training.—Adeline B. Gauger, M. D., in Medical Woman's Journal.

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PREVENTION OF INFIRMITY

It is not always easy to find suitable employment for an elderly worker who has already retired or for one who has suffered a disabling illness. That occupation is beneficial to most elderly persons can be seen by visiting any of the few "chronic sick" hospitals that have opened an occupational therapy department, where the satisfaction of the septuagenarians and octogenarians in their work is obvious.

Some employers are considering this problem, and research is being undertaken to discover what occupations are suitable for the elderly and what are the economic possibilities of their employment. It is now well recognized that the expectation of life has greatly increased during the past 50 years, that ageing in itself should be a simple painless process, and that the aged possess great powers of recuperation.

It is to be hoped that the nation will accept the challenge and will ensure that the extra years that have been given to man shall not be years of misery, frustration, and boredom.—British Medical Journal.

ATOMIC ENERGY

Atomic fission of heavy elements, as uranium and plutonium, is accompanied by heat comparable to that of the sun and the violence of an earthquake. The present bomb can produce 100,000 casualties—40,000 of which may be fatal. Statistics indicate that 20 per cent of casualties are a combination of radium sickness and flash burns, 60 per cent due to blast and fire, and 20 per cent varied. Such blast is several thousand times greater than the largest "ordinary" explosion ever produced.

Potentialities of this type call for philosophy, not resignation. Otherwise, panic could be worse than bomb damage in the event of catastrophe. Leadership in this inevitable phase of future wars must come from the medical profession.—Rocky Mt. Med. J.

DECORUM DECANORUM

What is to be done about the 15,000 applicants who are denied admission to medical schools every year? Why does this represent such an appalling aggregate of frustration and broken hopes? It is largely due to the fact that in most colleges the student who is preparing for medicine is set apart and classified as such. Certain "Premedical" courses are prescribed. He joins a "premedical" club. He identifies himself in his own medical career long before he has demonstrated an aptitude for such a calling. When the door to medical school is not opened to him, after he has publicly committed himself to it, it is as if it had been slammed in his face. He is humiliated. He finds himself unprepared both psychologically and by virtue of his specialized preparation to accept any alternative.

College administrators could alleviate much of this distress if they abandoned the term "premedical student" and took pains to prepare every prospective medical student for an alternative career if medicine were not open to him.—New England Medical Journal.

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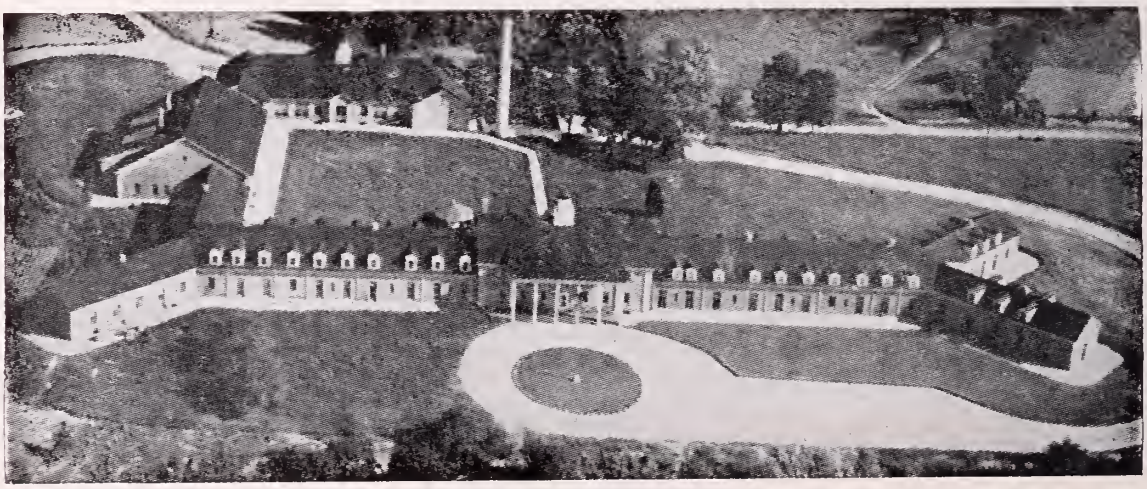

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BOOK REVIEWS

DISEASES OF THE FOOT—By Emil D. W. Hauser, M. S., M. D., Associate Professor of Bone Joint Surgery, Northwestern University Medical School. New, Second Edition. Pp. 415, with 195 figures. Philadelphia and London: W. B. Saunders Company. 1950. Price $7.00.

This is a well written book which covers about all the disabilities of the foot one encounters in actual practice. The physician doing general practice will find the book of much practical value with many excellent suggestions for treatment of common foot disorders. It may well be used for reference for the less common disabilities.

The orthopedic surgeon may differ with the Author on several counts and may wish to add worthwhile suggestions, but the treatise is not intended as a text for the orthopedic surgeon.—E. Bennette Henson, M. D.

THE LEAST "CORRUPTEST"

A friend asked Rastus if he had voted yet. "Yessah, I'se voted.—how did ah vote? Well boss, it was dis way. Ah meets a Democrat on the street and he gibs me 'leben dollahs to vote his ticket—den ah meets a Republican and he gibs me seben dollahs to vote his ticket, so ah voted for the Republican because—day is de least corruptest."—Anon.

CHESTNUT LODGE ROCKVILLE, MARYLAND

In addition to its current psychotherapeutic program, Chestnut Lodge now offers facilities for the care, study, and treatment of the elderly patient requiring psychiatric supervision.

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MLB LICENSES 23 DOCTORS

At the winter meeting of the Medical Licensing Board, held at the Capitol, in Charleston, January 5-7, 1950, twenty-three doctors were licensed to practice medicine in this state, seven by direct examination and sixteen by reciprocity with other states.

The following is a list of the doctors licensed by direct examination:

Barberia, Regina Margaret, Morgantown
Ison, Harry Cecil, Red Jacket
McNamara, Wm. Edward, Jr., Wheeling
Oakes, Alden Bayard, Portsmouth, Ohio
Rainbow, Kathryn Adeline, Oberlin, Ohio
Rosenbaum, George Robert, Richmond, Virginia
Zadinsky, Leo Walter, Quinwood

The following doctors were licensed by reciprocity:

Adelman, Samuel Irwin, Elkins
Berry, Elbert Lowell, Montcoal
Duckwall, Vernon Eugene, Elkins
Greco, Donald James, Omar
Hall, William Thomas, White Sulphur Springs
Harley, John Barker, Galloway
Harris, Max, Elkins
Hines, Brainard Evans, Charleston
Hoback, Florence Kunst, Huntington
Leibold, Robert Walker, Waynesburg, Pennsylvania
McMillan, Marcy Emory, Jr., Bridgeport
Muehleck, George Ernest, Jr., Charleston
Perkins, Powell Leon, Caretta
Seltzer, Leo Maurice, Charleston
Staker, Norman Wilhoit, Delbarton
Sullivan, Robert Joseph, Gary

The spring meeting of the Medical Licensing Board will be held at the Capitol, in Charleston, April 3-5, 1950.

SPEECH CORRECTION CLINIC

A clinic for speech correction among children is being held each Tuesday afternoon at the Marmet Hospital for Crippled Children, in Marmet, for the diagnosis and training of children afflicted with speech handicaps such as stammering, stuttering, cleft palates, and hairlips.

The clinic, which does not cover the so-called spastic defects unless the child is mentally capable of reading, is being sponsored by the Gift of Life Committee, of Charleston. Mrs. Margaret Maroney, a graduate of pathological speech, is serving as speech correctionist.

The clinic is being held for one hour each Tuesday afternoon beginning at three o'clock. There is no charge, but contributions are being received from those who desire to help further the program.

The only limit to our realization of tomorrow will be our doubts of today. Let us move forward with strong and active faith.—Franklin D. Roosevelt.

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THE PROBLEM OF PUBLIC RELATIONS

Since time immemorial the doctor has been the object of admiration and of love for his altruism and self-sacrifice, and he has been the object of jokes and cartoons for his lack of those qualities.

A peculiar symptom of the present itme is the fact that many people talk admiringly of their doctor, and the same people may talk in a derogatory manner of the medical profession in general, particularly of its mouthpieces, the medical societies and the A.M.A.

This discrepancy has been especially noticeable within recent years, that is, since certain government agencies and political pressure groups have subjected the medical profession to a barrage of calumnies and insults. But even in this smear campaign the individual doctor has remained remarkably unscathed, and the center of the attack has been directed against the medical societies, os if these bodies did not consist of individual doctors who in a democratic way elect their officers.

It therefore would seem that the position of the doctor as a person appears too strong to attack even by the government. This would indicate that the individual doctor is quite efficient in establishing public relations whereas "organized medicine" has been lagging in its efforts. It is for this reason that medical societies have been accused by newspapermen of still stalking in frocks and silk hats, and we have been advised to take them off, to roll up our shirt sleeves as well, and to go to work.

What can be done to change this state of affairs? Let us go back to the old and more popular definition of public relations: "Be good. Do good. Tell the world about it." It may be safe to state that the vast majority of physicians fulfill, or try to fulfill, the first two requirements. However, it may be well always to remember that we are an embattled group, and that the conduct of each one of us will, for better or worse, have its reflection on public opinion toward the medical profession in general.—Walter Crane, M. D., in Nassau Medical Journal.

TOGETHER WE STAND—

The Wall Street Journal tells the story of the physician down in North Carolina who asked his friend, a real estate man, to attend a meeting on socialized medicine. The friend refused and the doctor said:

"But aren't you alarmed at the threat of socialized medicine?"

"Sure I am," said the real estate man, "but where were your doctors all these years when the real estate men were fighting against socialized housing?"

The doctor had no answer.

The Wall Street Journal goes on to warn:

"The doctors fight socialized medicine, the real estate men fight public housing, each business or industry fights its own battles against government encroachment —but never together.

Divide and conquer is an old and well-proven strategy that swallows its victim, one by one, before they know they are bitten.—New York Medicine.

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Editor
WALTER E. VEST, M. D.
955 Fourth Ave.
Huntington, W. Va.

Managing Editor and
Business Manager
MR. CHARLES LIVELY
Box 1031
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THROMBOPHLEBITIS IN THE LOWER EXTREMITY AND ITS SEQUELAE

By JOHN E. SUMMERS, M. D.,
Myers Clinic
Philippi, W. Va.

During the past few years a rather respectable bibliography on the problem of thrombophlebitis in the lower extremity has developed due, perhaps, for the most part, to Homans of Boston.

Thrombophelebitis in the lower extremity usually is discussed in two main categories: (1) superficial thrombophlebitis developing in the greater and or lesser saphenous venous systems and (2) thrombophlebitis occurring in the deep veins of the lower extremity.

SUPERFICIAL THROMBOPHLEBITIS

Superficial thrombophlebitis must be differentiated from migratory phlebitis associated with Buerger's disease. Superficial thrombophlebitis is the most common complication of varicose veins. The disease usually is obvious, with inflammatory reaction occurring in part (or involving all) of the main trunks and branches of the greater and or lesser saphenous venous systems. Many surgeons prefer to treat this condition by immediate ligation of the great saphenous vein at the saphenofemoral junction. Others are using anticoagulants. One may also apply elastic bandages to the involved extremity and, after inflammatory reaction has subsided, extirpate the greater saphenous vein. In any case, it is a mistake to confine these patients to bed and thus assist the thrombosis to extend to the deep venous system.

Pulmonary embolism is not apt to occur from superficial thrombophlebitis.

DEEP THROMBOPHLEBITIS

Some authors divide deep venous thrombosis into two groups: (1) quiet deep venous thrombosis (the bland thrombosis of Homans, the phlebothrombosis of Ochsner) and (2) deep venous thrombophlebitis (phlegmasia alba dolens).

However, the majority of the workers in this field consider that deep venous thrombosis begins quietly in the venous plexus of the calf muscles. The venous thrombosis may remain localized and give rise to no symptoms; it may propagate in the veins giving rise to a longer or shorter clot projecting into the main venous channels, attached only at one end. At this stage in its development the thrombus may be easily detached giving rise to pulmonary embolism; in fact, physical signs usually are minimal at this time, and pulmonary embolism usually is the first clinical evidence indicative of the existence of the process.

With the progression of the deep venous thrombosis, the deep veins become completely occluded giving rise to the clinical picture of phlegmasia alba dolens. Deep venous thrombosis is prone to develop in patients over fifty years of age; it occurs with equal freqeuncy in medical and surgical patients. In medical patients it usually is associated with heart disease. The predilection of postpartum patients to phlegmasia alba dolens is well known. Deep venous thrombosis occurs more frequently in patients with intra-abdominal malignancy and after cer-

tain operative procedures, especially operations for uncomplicated hernia, benign prostatic hypertrophy, pelvic operations and gastrectomy. Gangrene and fractures of the lower extremities are associated with a high incidence of deep venous thrombosis.

PREVENTION OF DEEP VENOUS THROMBOSIS

Deep venous thrombosis usually can be prevented by instituting measures to prevent stagnation of the blood in the lower limbs. Leg exercises, elastic pressure bandages properly applied to the lower extremities and early ambulation are the essential measures. The prophylatic use of the anticoagulant, dicumarol, in selected patients has proved valuable.

EARLY DIAGNOSIS AND TREATMENT OF DEEP VENOUS THROMBOSIS

Every patient must be considered as a possible candidate for deep venous thrombosis. Even minimal pain or tenderness in the calf muscles must be regarded with suspicion. The "Boston School" developed and advocated ligation of the deep femoral vein distal to its profunda branch both prophylactically and as definitive treatment for deep venous thrombosis to prevent pulmonary embolism. A few surgeons have ligated the inferior vena cava in patients with extensive deep thrombosis.

At the present time the most popular method of treating deep venous thrombosis is with the anticoagulants heparin and/or dicumarol.

The greatest drawback to the use of dicumarol is the difficulty in obtaining accurate prothrombin determinations. If one can be sure that the laboratory reports are accurate, dicumarol can be used.

The anticoagulants should not be used if the patient has had an operation on the brain or spinal cord, a blood dyscrasia with a bleeding tendency, an ulcerative hemorrhagic lesion, subacute bacterial endocarditis, pregnancy or a recent cerebrovascular accident.

If immediate action is indicated one should secure a prothrombin determination and, if this is normal, give heparin 50 mg. intravenously and dicumarol 200 mg. orally. Heparin 50 mg. intravenously every four hours is given for twenty-four to forty-eight hours until the dicumarol has become effective. Instead of heparin intravenously every four hours one can give subcutaneously 200 mg. of heparin/Pitkin menstruum as a single dose. The daily dose of dicumarol is individualized, and depends on the prothrombin determination for that day. To be effective the patient's prothrombin percentage must be kept below 50 per cent and should not be lower than 30 per cent. One must not confuse the terms "prothrombin time" and "prothrombin percentage". The laboratory should report both values on each determination.

Occasionally one will see hemorrhage due to dicumarol therapy. This should be treated with large doses of vitamin K (60 to 80 mg.) intravenously and fresh whole blood transfusions.

In this country Ochsner popularized novocaine block of the lumbar sympathetic chain in the treatment of phlegmasia alba dolens. This form of treatment has not proven to be very helpful and is not widely employed at the present time.

THE LATE SEQUELAE OF DEEP THROMBOPHLEBITIS

While pulmonary embolism is the dreaded complication of early deep venous thrombosis, the postphlebitic syndrome consisting of edema, induration, pigmentation, varicose veins and ulceration of the leg is the late complication. One sees also the same changes in the leg of the patient with varicose veins, and the etiology is the same in both conditions, namely stagnation in the venous circulation of the leg. Definitive treatment of the ulcer in association with varicose veins is removal of the varicose veins. In the postphlebitic syndrome, however, the deep veins have been permanently damaged by the thrombosis. The valves of the deep veins have been damaged or destroyed. The venous circulation is damaged. In some cases superficial varicosities develop as a compensatory measure to assist venous return. The ulcers associated with the postphlebitic syndrome always can be healed by the repeated application of an Unna paste boot.

It is interesting to see, even now, women with ulceration of the leg due either to varicose veins or to an old deep phlebitis, who have been treated for years by various practitioners by the local application of all sorts of greases, ointments and pastes. When it is understood that these ulcers are due to venous stagnation the correct line of treatment becomes obvious. The patient can be put to bed with elevation of the extremity. Better still, the proper application of an Unna paste boot permits healing of the ulcer with no interference in the patient's work or habits. A new boot should be applied each week or so as it becomes soiled, until the ulcer heals.

As definitive treatment, if varices are the only cause, they should be removed. If the patient

has had a deep phlebitis, one can never restore the circulation to normal. If superficial varicosities are present they should be removed, and all communicating veins ligated after the patency of the deep veins has been assured by the application of a pressure dressing to the extremity. The patient who has had deep phlebitis will have to wear an elastic stocking and change her habits so as to prevent venous stasis in the extremity for the rest of her life.

A few workers have advocated removal of all superficial varicosities and interruption of the deep femoral vein below its profunda branch for the treatment of postphlebitic ulceration. I do not believe that this method of treatment has been generally accepted.

SUMMARY

Thrombophlebitis in the lower extremity is discussed as (1) superficial thrombophlebitis and (2) deep thrombophlebitis. The former does not endanger life, and the patient should be kept ambulatory. In the early stages of deep thrombophlebitis pulmonary embolism may occur. To prevent the development of deep thrombophlebitis, measures must be instituted to prevent stagnation of the venous blood in the leg. The anticoagulants, heparin and dicumarol, are the best means of treating deep thrombophlebitis. Accurate prothrombin determinations are necessary when dicumarol is used. Treatment should be continued for several days after the patient becomes ambulatory.

The late complication of deep thrombophlebitis is the postphlebitic syndrome consisting of edema, induration, pigmentation and ulceration of the leg. These ulcers always can be healed by repeated application of Unna paste boots. Definitive treatment may require excision of the varicose veins. The patient will have to institute measures to prevent venous stasis for the rest of her life.

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TRAINING THE MENTAL DEFECTIVE

Frequently the question arises among physicians, and also laymen as to the capacity of mental defectives to take training, and what constitutes this care and training. Mental defective as used here comprises the three levels, high grade (Moron), middle grade (imbecile), and low grade (idiot). Any program for mental defectives would embrace measures concerning the borderline level as well.

Society is beginning to realize its responsibility in regard to those of retarded mental development, and to give attention to salvaging human values heretofore permitted, in many instances, to become social liabilities. Every child should be trained to develop his fullest capabilities so that he may live a happy and useful life. A program of care and training of the mental defective must be adapted to the levels of intelligence. Through appropriate training even those of the lower levels can be aided.—Joseph E. Barrett, M. D., in Virginia Medical Monthly.

CIVIL DEFENSE

A Britisher is quoted as saying that the best defense against the atomic bomb is not to be there when the explosion occurs. There is no doubt that this is true. However, as long as there is even a remote possibility that atomic weapons may be used in warfare, the next best defense, so far as the populace is concerned, is to educate the public, and to organize the relief services which would be necessary if such a disaster occurred.

That a large number of people can be psychologically prepared for possible catastrophe, and can be organized so that they may control widespread damage, was proved by the similar preparation of the population of London prior to the extensive bombing of that city during World War II.—J. Indiana St. Med. Assn.

PUBLIC CANCER CONSCIOUS

Public education is an unending process using many vehicles for transmission. It is difficult to measure the extent of knowledge gained by the general public, but it is safe to say from the results of recent polls that at least half of our population is aware of some of the danger signals of cancer. While very few are aware of all such signs, more and more are realizing the importance of early detection. The gradual adjusted decrease in death among women is proof of progress.—J. Indiana St. Med. Assn.

A CASE OF EXSTROPHY OF THE BLADDER

By G. G. IRWIN, M. D., and
MORRIS H. O'DELL, M. D.,
Charleston, W. Va.

Apart from the satisfactory result, this report is thought to be of interest for two reasons. First, it supports Higgins' recommendation that these unfortunate patients can and should be operated upon during the first year of life; second, it draws attention to the method of ureteral transplantation as described by Cordonnier, wherein the older transplantation tunnel technics are abandoned and the anastomosis is made directly between bowel and ureteral mucosae.

CASE REPORT

J.D., a four month old white male, weighing 10 pounds, 15½ ounces, was admitted to the Charleston General Hospital, July 5, 1949 with a diagnosis of complete exstrophy of the bladder, complete epispadias and congenital prolapse of the rectum. Since birth the baby had had persistent diarrhea, also prolapse of the rectum, and for two days preceding hospitalization had had blood in the stool. The child was breast fed from birth and was receiving orange juice and cod liver oil in addition.

Physical examination on admission revealed a dehydrated, listless baby with dull facies. The skin showed loss of turgor and was inelastic. Temperature was 101 F. by rectum, pulse 120, respiration 30. The pathologic findings were confined to the abdomen and pelvis. The bladder was exstrophied; the ureters opened on the surface at the trigone of the bladder. The penis showed complete epispadias. The pubic bones were separated two inches. Both testicles were present just above the scrotum. A small umbilical hernia was present. Around the exstrophied bladder, the skin was reddened and irritated from constant urine contact. The rectum was beefy red and edematous, and was prolapsed almost two inches. The extremities were negative except for slight spasticity.

Laboratory work revealed hemoglobin 65 per cent, a red blood count of 4 million cells, a white blood count of 14,500, with 54 per cent lymphocytes, 2 per cent monocytes, 4 per cent stab neutrophils and 40 per cent segmented neutrophils. The urine was normal except for a faint trace of albumin.

A condensed milk formula supplemented with vitamins was started on admission. Kaopectate was given after each loose bowel movement. Sulfasuxidine was started. All temperatures except that on admission were taken by axilla. The temperature remained elevated for three days, reaching a peak of 103.6 F. on July 7, and gradually dropping as the diarrhea was controlled and hydration improved, until it reached normal on July 12, remaining normal thereafter except for an occasional slight rise.

On July 9 the prolapsed rectum was injected. It remained reduced until July 14. Between then and the time of the first operation on July 30, it would occasionally prolapse but could be reduced easily. On July 18 the child was placed on cow's milk. X-ray of the abdomen on July 22 was negative except for considerable distention in the loops of the bowel. Whole blood transfusions were given until, on July 28, the hemoglobin was 91 per cent, with 5 million red blood cells and 7,900 white blood cells. A low residue diet was started July 28. On the evening of the 29th the rectum was gently irrigated; 150 cc. of Hartman's solution was given at 6 a.m. the following day, and a Levine tube was passed and left in place after emptying the stomach.

Under light ether anesthesia supplemented with oxygen, a transverse abdominal incision was made at the junction of the bladder with the skin. The recti muscles were found to be widely separated. A small ureteral catheter was passed up the right ureter. The ureter then was located easily. It was divided slightly below the brim of the pelvis after a small incision was made in the overlying posterior parietal peritoneum. The sigmoid colon lying close to it was brought over to the ureter. A small incision was made in the colon just below the superior longitudinal taenia. On approximation there was no kinking or twisting of the ureter. The ureteral mucosa was anastomosed to be bowel mucosa by four interrupted sutures and four sutures were placed between the serosa of the bowel and the adventitia of the ureter to cause the ureter barely to invaginate the lumen of the bowel. The lateral posterior parietal peritoneum was then brought over the anastomosis and sutured to the sigmoid colon, completely covering the area with peritoneum. The cul de sac over the rectum was obliterated by interrupted purse string sutures and the rectum was attached to the lateral peritoneal wall on the left, thus suspending the rectum. After closure of the peritoneum, fascia and skin a rectal tube was inserted.

The child was placed under an oxygen tent but recovered so well that it was discontinued the same day. Subcutaneous feeding every six hours for 48 hours was given using Alidase to

cause a more rapid absorption. This also caused some edema of the scrotum. Wangensteen suction was continued for two days, then a low residue diet was started. Penicillin and streptomycin were given for a few days. The rectal tube was removed at the end of the 5th day. The temperature remained elevated for two days, the highest reading being 102 F. axillary on the evening of operation. Thirty-six hours after surgery the temperature returned to normal and remained normal. On August 5, five days postoperatively, urine began to pass through the rectum.

The second stage of the operation, transplantation of the left ureter into the sigmoid colon, was done August 27. It was necessary to permit a long interval to elapse between operations to allow a rash of the buttocks, caused by irritation from urine draining from the left ureter open on the abdomen, to heal. The same preoperative routine was followed as in the previous operation. The old transverse incision was opened. There were no adhesions. The portion of the sigmoid colon lying close to the left ureter was brought to the ureter and anastomosed in a similar manner as described previously for the right side. The same postoperative routine was carried out as previously described. The temperature elevated to 103.6 F. axillary on the evening of surgery, but twenty hours later was normal and remained normal. An intravenous pyelogram was made September 6 which showed good function of both kidneys. The left ureter was slightly dilated. The right ureter was not dilated.

On September 16 the bladder was removed by careful dissection without entering the peritoneal cavity. The rectus fascia over a small umbilical hernia was approximated. The rectus fascia could be brought to the inguinal ligaments from above downward without tension. The defect was closed in this manner. The skin and subcutaneous tissue were brought downward and from the sides, closing the area without undue tension. A low grade fever occurred for five days and, on examining the incision, there was some serious drainage. Ten per cent urethane and a penicillin solution contianing 10,000 units per cc. were used to irrigate the area frequently. In spite of this, an area 1½ inches by 1 inch, skin only, separated. When the drainage slackened, liquid chloresium dressings were used for three days and on October 7 pinch grafts were applied, these being taken from the right upper abdomen. On examination six days later, the grafts were found to be in good condition and the donor site was healed. An intravenous pyelogram made October 24 showed some dilatation of the right pelvis and ureter; the left side was normal.

At no time was this baby considered seriously ill. All operations were well tolerated, with a rapid return to normal. The baby was discharged October 27, 1949.

December 17, 1949, the baby, now ten months old, was returned to the hospital outpatient department for an intravenous pyelogram. His mother stated that he had been eating well since discharge and that he had gained in weight.

The examination revealed very little skin irritation of the perineum. This had been controlled by leaving off diapers. The weight was fourteen pounds. Intravenous pyelogram showed good function in both kidneys. There was marked dilatation of the right ureter. The kidneys were in good position. The kidney pelvises and calyces were not dilated appreciably.

The mother was instructed to return the baby every six months to the outpatient department for a routine examination.

COMMENT

Exstrophy of the bladder is a congenital anomaly in which the lower anterior abdominal wall and the anterior bladder wall are missing. The result is a constant discharge of urine together with constant exposure of the delicate bladder mucosa to trauma and infection. The condition not only inhibits the normal growth and development of the child but is a very serious threat to life itself. Various observers state that one-third of the number of such patients die before the tenth year of life and that from one-half to two-thirds are dead by the twenty-first year. It is interesting to note, however, that Wilhelm described a man from the Ozark hills who lived thirty-seven years before consulting a physician for bladder exstrophy, and that Rubovitz and Arnkoff describe a normal pregnancy in a thirty-one year old colored woman with bladder exstrophy.

The threat to life arises from several sources. The bladder being constantly open to infection, inflammatory changes occur in its wall, resulting in stricture of the ureter in the intramural portion; this in turn results in stasis, infection and hydronephrosis, and finally, death from uremia. The bladder mucosa may undergo metaplasia and eventually an epithelioma may develop. It is interesting to note that the pathologist reported that already this infant's bladder was showing marked cornification of its epithelium. Obviously, therefore, operation should be done

before marked changes have had time to occur. Furthermore, in infants there is less possibility of bowel infection and therefore less likelihood of infection at the site of the anastomosis.

Treatment is surgical. Efforts to close the bladder and establish urinary continence have not been successful. The treatment of choice is transplantation of the ureters into the bowel, removal of the bladder and reconstruction of the abdominal wall. In the present case, we elected to follow the newer method of transplantation as described by Cordonnier, and found it easier to carry out, with the results satisfactory.

No one as yet has been able to overcome the hiatus at the symphysis. A fibrous bridge causes the patient to walk with a waddling gait.

Repair of the epispadias may be accomplished when the penis has obtained sufficient size. This probably is indicated mainly for the cosmetic effect since there is a strong probability of sterility.

SUMMARY

A case of exstrophy of the bladder with complete epispadias in a four month old infant is reported. The ureters were transplanted into the sigmoid colon in a two stage mucosa to mucosa technic. The removal of the bladder in a third stage was followed by localized infection at the base of the penis. This was easily controlled, and pinch grafts were placed to close the small defect caused by the infection.

Acknowledgment is made to Dr. Jack Basman and Dr. J. Bankhead Banks, of Charleston, for their assistance in the care and treatment of this patient.

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I hold the unconquerable belief that science and peace will triumph over ignorance and war, that nations will come together not to destroy but to construct, and that the future belongs to those who accomplish most for humanity.—Louis Pasteur.

THE TEACHING OF PHYSIOLOGY AT WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE

By EDWARD J. VAN LIERE, Ph. D., M. D.,
Morgantown, W. Va.

To some of us it seems a pity that many (although by no means all) men in the practice of medicine regard certain of the basic sciences such as physiology, biochemistry and pharmacology as being rather distantly removed from clinical medicine. It will be noted that anatomy, bacteriology and pathology are not included, the reason being that most physicians look upon these sciences as quite essential to the modern practice of medicine.

Since I am a professional physiologist, it may well be that I am unduly sensitive about this. I cannot refrain from reminding the reader that many of the modern discoveries in medicine have been developed in the laboratories of biochemistry, pharmacology and physiology. I will not labor the point but will mention only a few: gastrointestinal flouroscopy, vitamins, ultraviolet irradiation for increasing vitamin D. content of food, estrogenic substances, sulfa drugs, and the development of the artificial kidney. While all of these discoveries are of great significance it would be not only uncharitable but foolish to belittle the importance of the research and observations made by those who are engaged in the practice of medicine. Medical science needs both types of workers.

This is not the place to relate the history of physiology. Nevertheless, I shall take the liberty of mentioning a few historic high lights so as to refresh the reader's mind. Physiology is an old science. Medical history relates that Jean Fernell, who lived from 1497 to 1558, was the first individual to employ Aristotle's word *physiologia* for a special aspect of medical knowledge. Not so long ago physiology and anatomy were taught virtually as a single subject. In this country, for example, Oliver Wendell Holmes, the poet-physician, taught both subjects at Harvard. Eventually, however, these sciences were presented separately. In 1871, Henry Pickering Bowditch, of Boston, was appointed Assistant Professor of physiology at the Harvard Medical School. He had the honor and the privilege of establishing the first physiologic laboratory in the United States. Other medical schools in this country soon followed Harvard's example. Today, of course, every approved school of medicine has a well organized and decently equipped physiologic laboratory.

Many physicians who graduated some years ago probably still feel that physiology principally

concerns itself with the study of the frog's muscle and nerve. This may have been true years ago, but it no longer obtains. The frog's muscle and nerve are still used, but the students perform, also, numerous mammalian experiments. What is still more important and interesting is that the student himself often is used as a subject in the modern physiologic laboratory.

It has been emphasized, and with reason, that the transition from the so-called preclinical sciences to the clinical branches presents a real problem to the student. This is true, although it is not as formidable now as it was formerly.

For the past fifteen years or more, a special effort has been made in the courses in medical physiology at West Virginia University School of Medicine to show the relationship and correlation between physiology and clinical medicine. If this can be done, I submit that the transition between the basic sciences and the clinical courses is much easier of accomplishment.

Attention is called to the accompanying table. If this be studied, it will be noted that the students perform many experiments upon themselves or upon their co-workers. For the main part, the table is self-explanatory. It will be seen that the class average is given as well as the average figures obtained by several former classes. The tests indicated in the table listing the results are performed by the students themselves under the careful supervision of experienced and mature laboratory instructors.

A few comments might be in order. It is admitted that the blood counts probably are not too accurate because of the inexperience of the workers. The remainder of the data, however, is reasonably reliable. All of the tests are of practical value and interest. The table does not give all the details; for example, the pulse and blood pressure determinations are taken in the sitting, lying and standing positions. Determinations are made, also, following exercise such as running up and down several flights of stairs.

The data given are listed on the blackboard in the laboratory and are left there throughout the entire course. The student is asked to incorporate the table in his laboratory notebook and to peruse it carefully.

Besides the tests shown in the table, a number of other procedures are performed; some of these, such as electrocardiography, electroencephalography and the visualization of the gastric movements under the fluoroscope obviously do not adapt themselves to tabulation.

Each student observes the recording by the instructor of an electrocardiogram on his laboratory partner. He is allowed to keep his own tracing in his notebook. Electroencephalography is demonstrated to a group of six students, one serving as a subject. Records of this experiment also are given the students. Gastric movement following the ingestion of a barium meal is demonstrated fluoroscopically to a group of three or four students. One student in this

Subject No.	Age Yrs.	Wt. lbs.	R.B.C. x 10^6	W. B. C. x 10^3	Hb Sahli g/100cc	Color Index	Sp. Gr. Falling Drop	Bl.Pr. Sitting	Pulse Sitting	Circ. Time Sec.	Cold Rise mm.Hg	Pressor Time Min.	Vital Cap. Liters	B.M.R.
1	25	138	5.40	7.97	16.0	1.01	1.0545	112/85	72	12.2	16	4	5.6	+ 6
2	23	180	5.23	9.55	14.8	0.95	1.0542	122/72	84	13.5	12	3	3.9	— 3
3	21	173	4.99	7.65	17.0	1.13	1.0590	124/80	76	14	30	6	4.5	—12
4	24	152	6.18	5.7	17.4	0.94	1.0565	114/76	72	14	2	4	5.2	— 7
5	26	146	5.21	6.3	17.8	1.14	1.0606	130/90	80	14.8	20	2	4.8	— 7
6	22	186	5.9	6.6	15.9	0.90	1.0568	116/86	79	17	16	2	5.8	—11
7			5.76	7.95	17.5	1.0	1.0569	132/82	99	6	10	4	4.1	+ 7
8	24	142	5.93	7.80	16.4	0.92	1.0596	140/90	88	15.5	4	4	4.2	— 1
9	28	197	3.91	6.35	16.5	1.41	1.0536	128/94	88	13.4	6	2	4.2	—15
10	22	136	5.44	11.57	17.3	1.06	1.0577	122/82	80	—	6	2	3.75	+ 2
11	28	139	4.54	5.67	16.2	0.90	1.0552	112/82	75	12.0	12	2	3.8	—11
12	21	200	3.60	7.50	17.0	1.57	1.0604	138/88	75	29.0	22	6	5.5	+ 1
13	24	160	4.93	6.95	13.8	0.92	1.0583	122/78	78	16.4	12	6	4.3	— 1
14			3.42	9.50	15.0	1.41	1.0579	*	*	*	*	*	*	*
15	25	134	5.16	8.95	18.2	1.17	1.0557	106/78	75	20.2	18	2	4.0	— 7
16	28	155	4.77	7.13	18.0	1.07	1.0597	118/78	80	18.6	8	2	4.5	— 9
17	25	163	4.55	6.55	14.1	1.03	1.0584	108/78	74	14	6	3	5.4	— 4
18	24	168	5.15	6.1	14.8	0.95	1.0591	130/90	78	11.3	12	2	5.2	—19
19	29	161	5.83	8.55	16.1	1.073	1.0547	118/72	72	10.5	14	2	4.8	+ 9
20	26	162	5.36	5.73	15.5	0.97	1.0564	130/82	90	14.6	10	3	4.6	—27
21	24	128	4.68	7.04	15.0	1.06	1.0562	126/88	66	15.8	16	4	3.7	— 5
22	22	116	4.14	8.02	12.9	1.00	1.0536	108/64	72	14	8	2	3.3	—16
23	26	162	4.96	9.37	16.1	1.07	1.0583	122/82	88	9.2	2	2	4.1	— 6
24	27	186	6.44	6.19	15.4	0.80	1.0596	122/82	88	—	12	6	4.2	+ 6
25	24	174	5.51	7.70	17.3	1.04	1.0597	110/80	87	14.4	6	3	5.4	—14
26	28	180	4.98	5.88	13.0	1.20	1.0564	112/72	74	12.2	18	4	5.4	— 6
27	21	193	5.24	8.68	15.7	1.00	1.0587	123/82	77	—	26	11	3.9	—17
28	23	146	5.36	7.35	16.2	1.05	1.0626	118/80	61	15	12	3	5.4	—13
29	25	154	5.27	6.75	16.5	1.04	1.0590	104/74	72	14	6	3	5.2	— 5
Average			5.19	7.44	16.3	1.06	1.0578	121/82	80	14.2	12.2	3.5	4.66	— 7
Fall 1948			5.07	7.45	15.3	1.00	1.0579	120/79	82	13.3	12.5	5.5	4.7	— 5
Summer 1945			5.18	7.20	14.1	0.92	1.0578	118/73	—	14.0	12.0	2.2	4.45	— 5
Winter 1944			5.10	7.90	14.7	1.00	1.0580	120/82	—	—	—	—	—	—

* Withdrew, poor health.

group serves as a subject. He is instructed to fast an appropriate length of time before taking the barium meal.

Besides the previously mentioned procedures, the student tests his vision by use of the Snellen chart. He is required, too, to chart his visual fields by means of a perimeter. In neurophysiology the important reflexes are demonstrated and the significance of these is discussed in making a neurologic examination of a patient.

The students are held responsible for the theoretic considerations underlying all of the previously named procedures. From time to time the instructor in charge holds an informal conference with the students and the results are explained and analyzed. Attention is called to deviations from the norm and the significance of these is briefly examined. This obviously cannot be done exhaustively, but neither is it done superficially. Let us take an example. If a student on several determinations is found to have a diastolic blood pressure of 90 mm. Hg., or more, or a systolic pressure of 140 mm. Hg., or over, it is pointed out that these figures are somewhat above the accepted normal range, and the significance is touched upon. Parenthetically, it should be stated here that care is exercised not to alarm the student. It is stressed that blood pressure values fluctuate a great deal, and that one or two readings may not mean much. This often can be demonstrated by taking the student's blood pressure at the next meeting of the class. Finally, it is emphasized that in medicine the diagnosis of disease is really based on physiologic principles, and it is stressed that the study of disease should be approached on a physiologic rather than on a pathologic basis.

It is felt by members of the Department of Physiology that the data which are given in the table and the results of the other experiments mentioned help prepare the student for his courses in physical diagnosis and for his work in medicine. I wish to emphasize that the norm is stressed rather than the unusual; in point of fact, the unusual is used mainly to emphasize the norm. Compilation of data such as appears in the accompanying table is of value also, in that it suggests the possibility of statistical research and the careful study of data. Perhaps it is too much to hope that it may even stimulate the future practitioner of medicine to do research. It is possible, however, that it might stimulate him to keep better records of patients.

Medical physiology obviously lends itself to this type of teaching perhaps better than any of the other basic sciences. It behooves the physiologist to take advantage of this, so as to help the student bridge the gap between the preclinical and the clinical sciences. It is at least one logical approach which I feel is eminently worth while and not difficult to accomplish.

Finally, in the teaching of physiology, as in the teaching of many other subjects, the importance of intellectual honesty and that of humility can be stressed. Indeed, it should make a student humble to learn that the actual cause of muscle contraction is unknown, that it is not fully understood why the heart beats faster during exercise, and that it is even extremely difficult to prove that exercise is beneficial to the human frame. Many more examples could be given, but these will suffice. By pointing out these gaps in our knowledge, it is easy to show how badly research is needed and, further, that it may take years before many of these problems are satisfactorily solved. The student can be made to see that a solution of these problems represents a real challenge. He realizes that a splendid chance exists for those who are intellectually keen, who are research minded, and who are not afraid of hard work and disappointments. Lastly, the idealist sees an opportunity, by solving these problems, to do an immeasurable amount of good.

PLANNED AID FOR THE AGED

Most of us who have spent much time with older people, either as individuals or as professional workers, are conscious of the painful readjustment which most of this group have had to make in a society so completely unprepared for their continued presence on earth.

If their lot is to be improved—and with it the lot of us who will take their places sooner than we would like—then there must be immediate and intelligent planning for education in the schools of both medicine and of social work. This planning must inevitably map out the interdependence of the two professions.

Possibly social workers could have medical men give them their orientation courses, and medical students could have social workers in a similar capacity.

There must be clear and definite emphasis upon the fact that a person in his old age tends to suffer greater social and health losses than at any other time, and that those losses tend likewise to be less compensable then than at any other period of his life.—Ollie A. Randall in Geriatrics.

NATIONAL HEALTH LEGISLATION

It is my considered judgment that legislation for health insurance is not yet in the legislative action stage and will not be in that stage, regardless of its merits, until there have been further hearings, further research, and until a primary basic administrative formula has been developed.—U. S. Senator Hubert H. Humphrey in New York Medicine.

De QUERVAIN'S DISEASE IN MOTHER AND DAUGHTER

By H. A. SWART, M. D., F. A. C. S.,
Charleston, W. Va.

Stenosing tendovaginitis of the wrist was first described in 1895 by the Swiss surgeon De-Quervain.[1] In this disease the sheath enclosing the tendons of the abductor longus and extensor pollicis brevis muscles is thickened. The sheath occupies the first compartment of the dorsal surface of the radius, near the styloid process. The disease is characterized by a small tender swelling over the radial styloid. Pain is produced by abducting and extending the thumb. Inability to grasp objects firmly is a common complaint. The pain may radiate to the elbow. This condition frequently is unrecognized, and is treated as arthritis or neuritis. X-rays of the bones of the wrist show nothing to account for the pain.

The cause of the thickening of the tendon sheath is not known. It occurs more commonly in women than in men, and many cases have been reported following prolonged use of the hands as in piano playing, typing and wringing out clothes. However, in other cases, there has been no definite history of any continuous use of the hand.

The treatment consists of making an incision over the swelling, incising the thickened sheath and leaving it open. The skin is then sutured.

Two cases which have been treated in the past two years and which occurred in mother and daughter are presented.

Case 1.—Mrs. M. W., first seen 2-1-47, age 54, white, female. Occupation: Worker in a glass plant where she assembled cardboard partitions for boxes containing bottles. She stated that a minimum of 1,485 partitions per hour had to be assembled in order for a worker to hold her position.

She had had pain over the right radial styloid for about 7 months. She could not extend her thumb fully, and at times the thumb caught as she tried to extend it. An X-ray had been negative. Resting the hand had caused the pain to become lessened, but on use it became worse again.

There was a firm, soft, tender swelling over the radial side of the radial styloid. Extension of the thumb was limited 30 per cent. Flexion and adduction were normal.

A diagnosis DeQuervain's disease was made, and operation was performed on 2-18-47 under local anesthesia. The sheath enclosing the tendons of the abductor longus and extensor pollicis brevis was found to be moderately thickened, and was split. It was then seen that the tendons themselves were thickened at this point. There was a small amount of reddish gelatinous material present between the tendons. The sheath was left open, and the skin closed with cotton sutures. A plaster was applied with the thumb in moderate abduction.

Pathologic report of specimen from thumb: Several small pieces of firm, grayish-white material.

There is one small piece of tendon sheath present showing thickening and enlargement of the lining cells. There is a small amount of blood pigment present beneath the surface. The second piece is from the tendon, shows increase in fibroblasts and a small amount of fibrinoid material lying on the surface. *Diagnosis*: Chronic tenosynovitis, probably traumatic (extensor tendon of thumb).

The sutures were removed in 9 days, and the splint left off after the 11th day. The patient was instructed to use warm baths, massage and exercises at home under which regimen she slowly improved.

On 7-7-47, almost 5 months postoperatively, she could extend the thumb normally and without pain. All wrist and finger motions were normal, but the grip was not quite as strong as before. She returned to work shortly afterward. She was again seen on 11-28-48, 9 months after operation, when she came in with her daughter. At that time, the thumb was completely painless, and the patient had no symptoms. Examination of the hand and wrist was negative.

Case 2.—Mrs. R. J., daughter of the patient in case 1, was first seen 11-28-47. She was 35 years of age, and did no work except housework. She had had pain over the right radial styloid for over 2 years. She said she had bruised the wrist in an automobile accident about 2 years. before. At that time the thumb was thought to be sprained, but no x-rays were made. The thumb had been taped up at one time without relief.

Two nights before I saw her she had baked a cake and had used the right hand to beat up the batter. The next morning the wrist pained her severely, and she could not use the hand to brush her teeth. The day that I saw her there was some improvement, but she could not use the thumb to button up her clothes. She said that as she tried to use it, it would pop loudly.

There was a definite mass over the radial styloid. There was no loss of extension of the thumb, but extension was painful. She referred the pain to the tendon of the extensor pollicis brevis, just distal to the radius. There was no grating or loss of forearm motion. X-ray of the wrist were negative.

A diagnosis of DeQuervain's disease was made and a splint was applied to immobilize the wrist and hand. She returned four days later, having removed the splint the day before, as it had done no good.

On 1-13-48 operation was carried out under pentothal anesthesia, at the patient's request. The sheath enclosing the tendons of the extensor pollicis brevis and abductor pollicis was found to be thickened and there seemed to be 3 tendons in the sheath. The tendons themselves were not thickened. The sheath was left open and the skin closed with cotton sutures. A plaster splint was applied holding the thumb in extension.

Pathologic report of specimen from tendon sheath of right wrist: Specimen consists of three small irregular-shaped pieces of grayish-white tissue measuring 0.8 by 0.4 cm.

The pieces show some tendon and tendon sheath. There is some connective tissue proliferation. *Diagnosis*: Stenosing tenovaginitis (De Quervain's disease).

The sutures were removed in 9 days, and the splint in 11 days, as in the other case. The patient was instructed in the use of warm baths, massage and exercises at home. On 3-19-48, 2 months postoperatively, she had complete thumb motion with very little pain. She was instructed to return again in 4 weeks but did not do so.

In the case of the first patient, it would seem that the occupation was a definite factor in the production of the disease, but in the case of her daughter there was no occupational factor. She was a housewife, and carried out the usual household duties. It is possible that there may have been a hereditary factor, but X-rays of both wrists were completely negative.

Fig. 1.—Showing small swelling over radial stylaid, typical of De Quervain's disease (case 2).

In a reasonably complete review of the literature in English, no other cases were discovered in which blood relatives were affected. One of the earliest articles was by Schneider[2] who advocated conservative treatment by means of plaster casts. This treatment seemed to be beneficial, but the time required for cure was several months longer than that which followed operative treatment. The most complete article which I found in the literature was that of Finkelstein[3] in which 24 cases were reported

COMMENT

I believe it is worth while to again call attention to this condition because it is frequently overlooked and misdiagnosed. The treatment is simple and effective. The finding of the condition in a mother and daughter is unique and leads to speculation regarding a possible hereditary factor. The wrists in these women may have been formed in such a way as to predispose to irritation and thickening of the tendon sheath. However, X-rays in both cases showed no variation from the normal. The thickening of the tendons themselves in the first case is similar to that described in several cases in the literature. However, the history of pain was much shorter (7 months) than that in the second case (2 years) in which the tendons were not thickened.

SUMMARY

Two case De Quervain's disease (stenosing tendovaginitis occurring in mother and daughter are reported. No account has been found in the literature in which the disease occurred in blood relatives.

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Approximately one in twenty-five deaths from coronary disease in males and one in seven deaths in females are associated with diabetes.—W. S. R. in Detroit Medical News.

PARATHION POISONING

By J. J. LAWLESS, M. D.,
Morgantown, W. Va.

Commercial fruit growing in West Virginia and other states requires the extensive use of potent insecticides to control the noxious insects which can destroy entire crops in a few days. Many such insecticides are toxic for man and domestic animals also, so that extreme care must be taken to prevent poisoning. Among the more recent and more potent substances are the organic phosphates, of which the most widely used is known as parathion.

Parathion is diethyl-nitrophenyl thiophosphate. Other similar phosphates, with similar properties and toxicities, are known as HETP and TEPP. Parathion is a liquid but is supplied for horticultural use as a powder from which formulae for dusting or spraying can be prepared. In tests on certain insects, parathion is about two hundred times as toxic as nicotine.[1] In animal experiments an oral dose of 3 mg. per kilogram resulted in the death of one-half of the number rats to which it was given. The symptoms were lacrimation, salivation, intestinal hypermotility and generalized fibrillary tremors. Death from respiratory failure occurred within twenty-four hours.

Although the lethal dose for man is unknown, there is no doubt that these substances are highly toxic for humans. Several deaths have occurred in orchard workers exposed to parathion in spraying and dusting operations. The symptoms were headache, nausea, blurred vision, dizziness, shortness of breath, pressure in the chest, abdominal cramps and diarrhea. Miosis, lacrimation, excessive salivation and sweating, and extreme muscular weakness also have been observed.

The effect of parathion is to inactivate the cholinesterase of the blood and tissues so as to produce the effects of marked parasympathetic stimulation as just indicated. Atropine is the logical and effective medication, and should be used in doses sufficient to keep the patient fully atropinized. Doses of 1 to 2 mg. (gr. 1/60 to 1/30) may be given hourly up to 10 or 20 mg. daily. It may be necessary to invert the patient to aid in the coughing out of mucus, or it may be necessary to remove mucus by means of a tracheal catheter. The stomach should be emptied of accumulated secretion by means of a Levine tube, and oxygen should be administered early because of the danger of pulmonary edema. Muscular weakness may be so extreme as to require artificial respiration. The emergency lasts from twenty-four to forty-eight hours, and the patient must be watched carefully during this period. Recovery may be hoped for even in severe poisoning, requiring many hours of artificial respiration.

As the regeneration of cholinesterase is slow, susceptibility to further poisoning is increased after one episode. Small daily exposures increase susceptibility, and exposure to HETP and TEPP, which similarly inactiveate cholinesterase, produces similar sensitivity.

Parathion is absorbed through the skin by contamination with oily or aqueous solutions, or dust, and through the lungs and digestive tract by inhalation or ingestion of dusts or sprays. Poisoning can be prevented by care in the handling and use of parathion, as advised by the manufacturers[2]. Orchard workers are accustomed to using arsenates, nicotine, DDT and other toxic substances with safety, but must be warned of the much greater toxicity of the organic phosphates.

SUMMARY

Parathion is a new and potent insecticide used in orchards and other types of agriculture for the control of insects. It is highly toxic for man, and may be absorbed through the skin, digestive tract and lungs.

Early symptoms of poisoning include headache, blurred vision, nausea, dizziness, dyspnea, cramps and diarrhea. At the onset of any of these symptoms, the use of parathion should be stopped immediately, and a physician consulted. The immediate administration of atropine is desirable.

Treatment is urgent, and includes atropine in large doses, postural drainage, oxygen and, sometimes, artificial respiration. The emergency lasts from twenty-four to forty-eight hours, and recovery may be hoped for even after many hours of artificial respiration, if treatment is prompt and adequate.

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The most immediate goal of the Department of Health of West Virginia is to provide basic health services for our entire population. I am hopeful that this goal will be reached within the next few years.—N. H. Dyer, M. D., State Director of Health, in Health News.

The President's Page

The success of open meetings being sponsored by component medical societies augurs well for similar meetings being planned for the future. An example is the recent psychiatric-diabetic program arranged by Kanawha Medical Society, and held in Charleston.

The afternoon session was limited to members of the medical profession, but the night session was open to the public. The ballroom at the Daniel Boone was crowded and probably as many as a hundred people turned away.

Programs of this character are undoubtedly of considerably more than passing interest to doctors as well as laymen. One-day refresher or post-graduate programs devoted to some subject of general interest would, I earnestly believe, receive support from the great majority of doctors in the areas where held. In addition, the idea of open meetings could well be developed by all of our societies.

I again call the attention of the members to the importance of attending the annual meeting at White Sulphur Springs, July 27-29, 1950. The program committee has selected speakers for the scientific sessions with the greatest of care. These speakers come to West Virginia with the full knowledge that their addresses will be heard by an audience composed predominantly of general practitioners. While nearly all of the specialties will be represented on the program, the papers will, I feel sure, be of interest to every member of the Association.

The importance of attending meetings of a local or district character, as well as sessions sponsored by state and national groups, has never been more apparent than at the present time. Our members owe it to themselves, as well as to their local society and the State Medical Association, to make every effort to attend the annual meeting at White Sulphur Springs. Those who are working so hard to make the meeting a success deserve the full support of our members.

C. E. Watkins

President.

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TOXICITY OF COMMERCIAL INSECTICIDES

Organic research stimulated by war-time needs has resulted in the development and commercial production of many compounds with valuable peace-time properties. Among the more useful of such compounds have been poisons, such as DDT, 1080, parathion, and others, which find extensive application in the control of insect and animal pests.

The active insecticides parathion and its related compounds HETP and TEPP have been used in West Virginia fruit growing areas with great success in the control of destructive pests. Unfortunately these compounds are exceedingly toxic for man, and poisoning is certain to occur unless great care is used.

During the 1949 season at least three deaths from parathion poisoning occurred in the United States. In these cases the outcome resulted from lack of adequate protective measures and from failure to seek medical aid at the onset of symptoms. Early and active treatment, as described in an article on parathion poisoning published in this issue of the Journal will usually be successful in preventing death.

It becomes the duty of physicians in fruit growing areas to familiarize themselves with this new type of poisoning, and to be prepared to treat it intelligently. We regret the need for exposure to compounds of such toxicity, but must be prepared to care for the victims of their use, while we wait expectantly for equally active insecticides without such potency for harm to man and his domestic animals.

WELL-CHILD CONFERENCES

There seems to exist some misunderstanding among physicians as to the purpose and conduct of the well-child conferences. It would appear desirable, therefore, to outline the policies of the conferences as recently issued in a Handbook of Procedures for Clinicians by the State Department of Health.

The main purpose of the well-child conference is to provide health education and preventive medical care for the children and parents who are unable to obtain private health supervision. Due to the fact that a great deal of confusion exists as to the children for whom the conferences are held, it has been found necessary to define eligibility. Only children coming under the following catagories are eligible to attend:

Care for the pre-school child who is not ill and is referred to the conference by:

1. A physician;
2. A welfare or social agency; or
3. A public health nurse because the child has no private health supervision.

In order to make sure that the parents and children who need this service are the ones who attend, it is suggested by Dr. N. H. Dyer, state director of health, that a referral card from one of the above named groups accompany the patient. In this way the clinician can be certain that he or she is rendering service where it is really needed, and that many more clinicians will become interested in staffing well-child conferences throughout the state.

ARE DOCTORS CITIZENS?

There has been plenty of evidence in recent years to suggest that some people in this country are not altogether certain of the answer to the question: are doctors citizens?

The astonishing demand from several political sources that payment for doctors' services be made by government paymasters, is compelling indication that some people think the doctor is different from other citizens, with a different sort of civic obligation and a different sort of individual rights.

No other professional man in America—no businessman, no butcher, no plumber, no baker, no clergyman, no grocer, so far as we know—has to date been nominated to share with the doctor the dubious distinction of having his in-

come paid by the government and his product or service made "free" to all comers. It is conceivable such suggestions may come later. Certainly in the logic of socialism, a case could be argued for making the work of all these essential people a function of government.

There are a good many things American citizens won't stand still for — and don't expect other citizens to stand still for either. Which brings us back to the question, "Are doctors citizens?"

We'll know more about the answer after next November. The coming congressional elections will give the whole country a good yardstick with which to measure the citizenship of the medical profession.

Is it a citizenship that influences government, a citizenship that is informed about candidates, a citizenship that means registration, voting, working for the candidate chosen? Or is it negative and passive when faced with the vital issues of an urgent time? Is it too busy to be concerned with the public business of democratic government?

The answer is up to every doctor. And the testing time will be the coming elections — the primaries as well as the general election in November.

This is the time for doctors to demonstrate in action what their citizenship means in America. Conceivably, it may be the last time.

AMA COMMENTS ON STATE CONFERENCE

The following report of the press-radio conference sponsored by the Public Relations Committee of the West Virginia State Medical Association and held at Charleston March 12, appears in the April 10 issue of the Secretary's Letter distributed nationwide to medical groups by Dr. George F. Lull, secretary of the American Medical Association:

"State's Doctors Learn Something of Press Relations" was the heading which the Charleston Daily Mail recently put over a front page story which reported on the first doctor-press-radio conference to be sponsored by the West Virginia State Medical Association.

Dr. Frank Holroyd, state society public relations chairman, promised the statewide newsmen, magazinemen and radiomen present that their complaints would be carried to the state medical society and that they would be acted upon in an effort to "create more harmonious atmosphere between the profession and news disseminating sources."

Nine of the 13 audience questions asked of the state society panel in the Sunday afternoon session pertained to the A.M.A. and the medical profession's policy and activities. Called for was more information about the A.M.A.'s alternative to compulsory health insurance and what other positive action is favored by the doctors of America. Lawrence W. Rember, director of A.M.A. public relations, gave a number of positive answers which were reported fully in the press of West Virginia.

The very successful conference first heard six 10-minute talks by representatives of the press and radio. A panel to answer any and all questions following the talks consisted of the state medical society president, chairman of the council, medical school dean, health officer, PR committee chairman and members, and Mr. Rember.

Brought out by the newsmen were these points:

Doctors make more news than the average citizen. The use of a doctor's name lends greater credence to a story. Also, radio stations need an authority to quote because they still are afraid to editorialize. Thus, doctors should overcome their fear of having their names used in print or on the air.

Doctors and hospitals should be encouraged to report news when it occurs, and hospitals should have a doctor available for questioning on accidents. A hospital once refused to report an accident on request, but later wanted that same newspaper to run a feature story on its x-ray machine.

SURVEY OF DOCTORS' INCOMES

Arrangements have been made by the AMA Bureau of Economic Research and the office of Business Economics of the U. S. Department of Commerce for a joint survey of physicians' incomes. The survey is scheduled to begin late in April.

The Bureau has been authorized by the AMA Board of Trustees to cooperate in this survey, which the Department of Commerce had planned to conduct alone. It will be the first full-scale survey by the department of physicians' incomes since 1941.

An analysis of the results will be published by the Department of Commerce next fall in its monthly publication, "Survey of Current Business." Its August, 1949, and January, 1950, issues had published similar analyses of surveys of incomes of dentists and lawyers, respectively, made jointly with the American Dental Association and the American Bar Association.

There is evidence that the national averages in some surveys have been too high because physicians who do not have bookkeepers to fill out questionnaires do not reply in sufficient numbers. Accordingly, the Bureau emphasizes the importance of all doctors, especially those with a relatively small practice, filling out the questionnaires.

Accurate postwar data on physicians' incomes is badly needed in order to develop better estimates of how much the American people pay to physicians.

We are informed that the survey has no relation whatsoever to the operations of the U. S. Bureau of Internal Revenue, and that there is no way by which the Department of Commerce could have obtained the needed information

from the Bureau of Internal Revenue; hence, the questionnaire survey.

There will be two questionnaire forms. The Bureau of Medical Economic Research helped to design these. A short form will request income data for 1949 only. A long form questionnaire will cover the years 1945 through 1949. All are to be returned unsigned in franked envelopes.

The punch card files of the Bureau of Medical Economic Research contain the names of about 200,000 physicians. The survey will cover 125,000 of these, or 62½ per cent of the total. Selection will be by a formula which eliminates any partiality.

A short form will be sent once only to every other name in the file. Of the remaining 100,000 names, every fourth will be selected. To these will go 10,000 short forms and 15,000 long forms, with this distinction—the return franked envelopes will carry a code number which will identify the physician to the Bureau of Medical Economic Research alone. All of the addressing will be done in the headquarters of the AMA.

The sole purpose of the code number is to enable the Bureau of Medical Economic Research to address a follow-up letter to those not replying to the first request.

Physicians will be doing the medical profession a service by filling out the forms and returning them as soon as possible.

"GRASSROOTS" OBLIGATION

". . . The A. M. cannot support or oppose candidates for public office. That is not the province of the A. M. A. or of State and County medical societies. But every doctor, in his own community, if he believes in sound medical practice, and if he believes in maintaining American freedom, not only has the right to support candidates who square with his convictions but he has a sacred obligation to do so."

This exhortation, from the report of the Coordinating Committee of the A. M. A. given at the December, 1949 meeting in Washington, should be heeded by every physician. He should find out, before casting his ballot, how every candidate for public office stands on the President's socialized medicine proposal. And if he should get his patients to do likewise, candidates will understand, unmistakably, the sentiments of the voters. —Norfolk Medical News.

Patients with secondary anemia must be reminded that certain foods have a high therapeutic iron content, chief of which are apples, apricots, beef kidney, livers, prunes, peaches, raisins, raspberries, red meats and green vegetables. Supportive hygienic measures of sunlight, sufficient rest and freedom from mental stress and strain also work wonders for the tired, wan victims of nutritional anemia.—R. N.

TUBERCULOSIS ABSTRACTS*

Exact figures on tuberculosis in rural areas are not available. The recording of deaths in the United States before 1937 was by place of occurrence, not by place of residence. As hospitalization of the tuberculous in sanatoriums, usually located in country districts, increased, more deaths were artificially credited to rural places. Census Bureau definitions of "rural," moreover, have been changed as has the accuracy of death reporting in country districts. Despite these limitations, certain general trends in the tuberculosis death rate, as between cities and rural districts, are evident.

While tuberculosis mortality has been declining in urban and rural sections alike, it is probable that the rate of decline in the cities has been greater than in the country. In 1890, when hospital deaths were too few to influence the rural-urban comparisons substantially, the death rate for pulmonary tuberculosis in the cities of registration states was 62 per cent higher than the rate in the rural parts of these states. The differential fell to a total urban rate (49.4 per 100,000) only about 20 per cent higher than the rural rate (41.3 per 100,000) in 1940.

Accurate urban and rural tuberculosis death rates cannot be determined for any year since 1940. It is estimated, however, that the approximate urban tuberculosis death rate in 1946 was 38.7 per 100,000 and the rural rate 34.9. These figures represent a further decline of the urban rate at a more rapid pace than that of the rural rate.

Controlling tuberculosis in rural America is made difficult by the same factors that impede the provision of general public health and medical services. Low per-capita income and low population density, with concomitant deficiencies of medical personnel, facilities, and health agencies, create handicaps in the battle against tuberculosis as against most diseases.

The attack on rural tuberculosis cannot be effective unless it is launched on all fronts of rural health service. Rural housing, education, nutrition, and general living standards must be elevated. The services of competent physicians must be available for the everyday care and prevention of illness and hospital services must be expanded as needed. Public health agencies must be extended and X-ray services for periodic chest check-ups must be made accessible. Social measures for the families of persons disabled with tuberculosis must be provided.

Unless these steps are taken, we may expect a permanent reservoir of tuberculosis to smolder indefinitely in rural districts. With these steps taken in city and country alike, tuberculosis can be eradicated from America.

Tuberculosis and its Control in Rural Areas, Milton I. Roemer, M. D., M. P. H., Public Health Reports, October 7, 1949.

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*Issued monthly by the National Tuberculosis Association and furnished through the courtesy of The West Virginia Tuberculosis and Health Association.

GENERAL NEWS

COUNCIL REAFFIRMS STAND IN FAVOR OF FOUR-YEAR SCHOOL IN STATE

The Council of the West Virginia State Medical Association has again unanimously reaffirmed its position and that of the Association's House of Delegates in favor of the establishment in this state of a four-year school of medicine and dentistry of West Virginia University.

The vote, which came at the end of a long session on Sunday, April 16, at Charleston, was unanimous. Several members spoke in favor of a continuance of the fight for the creation of the school by the Legislature, but all expressed the opinion that no further action could or should be taken by the council or house of delegates until the report is submitted by the legislative interim committee. The matter of location of the school did not enter into the discussion.

There seems to be no doubt that a four-year school will be one of the main items of business for discussion at the annual meeting of the House of Delegates in July. It is thought that by that time a report will have been submitted by Dr. Herman G. Weiskotten, dean of Syracuse College of Medicine, and Dr. Wilburt C. Davison, dean of Duke University School of Medicine, who, at the request of the legislative interim committee, have been studying the advisability of the establishment of such a school in this state.

State Grievance Committee

The Council accepted the report of the Committee on Constitution and By-Laws, submitted by the chairman, Dr. Sobisca S. Hall, of Clarksburg, recommending an amendment to the by-laws providing for the creation of a state grievance committee to consider complaints made by laymen against members of the medical profession. The amendment as prepared provides that complaints may be filed directly with the committee or submitted by the board of censors of a component society when it is found that such complaints cannot be settled at the local level.

At the present time, councillors are authorized to receive and adjudicate certain complaints when they cannot be settled within a component society. They serve as censors in their respective districts, but the council itself now constitutes a board of censors for the State Medical Association to which appeal may be made by members from the decision of any councillor.

The point was again emphasized that, while it is important that a state grievance committee be created, efforts should be made to have all controversies involving ethics, conduct of members, and services rendered heard and settled by component societies.

The amendment, which must be approved by the House of Delegates, provides that the grievance committee is to be composed of the five living immediate past presidents, listed in the order of their service, with the first immediate past president heading the list. When a president completes his term of office, he would automatically become a member of the committee, and the name of the fifth member would be dropped. In the future, all living past presidents would serve for a term of five years as a member of the committee.

Licensure Prerequisite to Membership

The Council also approved an amendment to the constitution, submitted by the committee, which would limit membership to doctors of medicine "licensed to practice in West Virginia who are members of a component medical society of the West Virginia State Medical Association." A similar amendment to the by-laws, approved by the council, could not become effective until after the amendment to the constitution is adopted. The constitutional amendment will be submitted at the annual meeting in July but cannot be put to a vote until 1951.

Succession in Office

Another amendment to the by-laws, included in the report, provides for succession in office in the event of the incapacity of the president elect to qualify as president.

Dues Increase Recommended

The Council also unanimously approved the recommendation of the committee for an increase in annual dues from $15.00 to $25.00. As this would be an amendment to the constitution, no vote can be had until 1951, although it will be submitted at the annual meeting in July. The final recommendation made by the committee on constitution and by-laws, that a committee be appointed to study the advisability of completely revising the by-laws, was unanimously approved.

Before becoming effective, all of the proposed amendments to the by-laws must be adopted by the House of Delegates.

Composite Licensing Board

The report of the fact finding and legislative committee, submitted by Dr. Frank V. Langfitt, of Clarksburg, recommending the creation of a composite medical licensing board, was received and the recommendations unanimously approved. Drs. James S. Klumpp and Walter E. Vest, of Huntington, members of a subcommittee heretofore appointed to consult with a similar committee from the State Osteopathic Society, reported fully concerning meetings that have been held by the two groups during the past several months.

The proposal, which will be on the agenda for consideration by the House of Delegates at the next annual meeting, provides for a licensing board to be composed of six doctors of medicine, two chiropodists, two chiropractors, and two osteopathic physicians. The state director of health would continue as ex officio member of the board, and the osteopathic physicians would be voting members.

The proposed legislation would provide that in the future osteopathic physicians are to take the same examination as doctors of medicine in applying for licensure in West Virginia. The status of osteopathic physicians in practice at the effective date of the legislation would not be changed in any way. The members

of the council were reminded that under the provisions of a bill passed by the Legislature in 1923, osteopathic physicians and surgeons licensed in West Virginia were afforded the same rights as physicians and surgeons of other schools of medicine.

The new law would include a provision to the effect that all persons at the present time legally licensed to practice medicine and surgery, including doctors of medicine as well as osteopathic physicians, would be permitted to continue in practice; however, applicants for licensure in the future would have to be graduates of medical schools approved by the Council on Medical Education and Hospitals of the American Medical Association, the Bureau of Professional Education and Colleges of the American Osteopathic Association, or the American Association of Medical Colleges.

The bill would also provide that applicants must have at least two years of academic work of a collegiate grade in a standard college of arts and science of equal rank with such college in West Virginia University. In addition, they will have to have served satisfactorily for one year as an intern in a hospital approved by the American College of Surgeons, or the committee authorized by the American Osteopathic Association to grant such approval.

State Blood Bank

The special committee on state blood bank, named pursuant to a resolution adopted by the House of Delegates in 1949, submitted a report signed by Drs. Sobisca S. Hall, Hu C. Myers, and W. J. G. Putschar. Doctor Hall was chairman of the group and Doctor Myers served as secretary.

The following recommendations were made by the committee:

1. That the West Virginia State Medical Association not attempt to establish a statewide blood bank system at the present time.
2. That, in lieu of the establishment of a statewide blook bank, the State Medical Association secure and keep information on the blood banks of the various hospitals of the state.
3. That the State Medical Association secure and keep information relative to the location and size of volunteer and professional donor lists of hospitals, medical societies, labor unions, civic organizations, Red Cross, etc.
4. That this information be made available to the hospitals of any area affected by a disaster.
5. That a permanent committee on blood banks be established which will coordinate the activities of the various banks, and work in an advisory capacity with such banks.
6. That the State Medical Association and its component societies give active cooperation to all organizations maintaining blood banks and donor lists.

The Council accepted the report unanimously, and it was ordered that the same be submitted to the House of Delegates for consideration at the next meeting.

Exhibit at State Fair

Following the recommendation of the Mercer County Medical Society, it was ordered that the State Medical Association join with the State Department of Health, the West Virginia Tuberculosis and Health Association, the West Virginia Heart Association, and the West Virginia Cancer Society, in sponsoring a health exhibit at the annual state fair to be held in Greenbrier County in the fall of 1950. The chairman was directed to appoint a member of the Council to consult and cooperate with Dr. N. H. Dyer, state director of health, in arranging for the exhibit.

Junior Academy of Science Award

Upon recommendation of the West Virginia Academy of Science, of which Dr. E. E. Myers, of Philippi, is secretary, it was ordered that an award of $10.00 be offered by the West Virginia State Medical Association for the best paper on a medical subject submitted by a member of the Junior Academy of Science before the annual meeting at Oglebay Park, Wheeling, in May. It was understood that the subject is to be selected by the West Virginia Academy of Science and that the papers will be judged by members of the faculty of Bethany College.

AMA and State Dues

The executive secretary reported that, as of April 15, more than three-fourths of the members had paid AMA dues. He further reported that nine component societies had already reported a one hundred per cent payment of state dues.

Honorary Members Elected

The following doctors were elected to honorary lifetime membership in the West Virginia State Medical Association:

Albert Greenway Rutherford, Huntington
Isaiah Welch Taylor, Huntington
Hugh Duncan McPherson, Eskdale
William James Glass, Sissonville
George Lewis Pence, Hinton
Walter Conner Hall, Welch
Richard Keene Bragonier, Keystone
Benjamin Jordan Read, Lynchburg, Va.
(formerly of Welch)
James McClung, Richwood
Shirley M. Prunty, Parkersburg
Otto Worthington Ladwig, Wilsonburg

AMA Associate Fellowships

Doctors Arthur Anderson Shawkey, Charleston, James Cleveland Collins, Fairmont, David Davis Hatfield, Yukon, and Clyde Whitby Vick, Bluefield, were nominated for Associate Fellowship in the American Medical Association.

Pre-Convention Meeting Scheduled

The Council adjourned to meet at White Sulphur Springs Wednesday, July 26, the day preceding the opening date of the 83rd annual meeting of the West Virginia State Medical Association.

DOCTOR GUY R. POST HONORED

Dr. Guy R. Post, of Parkersburg, director of the Wood-Parkersburg Health Department, has been certified as a Fellow by the American Board of Public Health and Preventive Medicine.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

INTERSTATE MEETING PLANNED BY EENT GROUPS AT WHITE SULPHUR

A joint meeting of the West Virginia Academy of Ophthalmology and Otolaryngology and the Virginia Society of Ophthalmology and Otolaryngology will be held May 7-9, 1950, at The Greenbrier Hotel in White Sulphur Springs.

The following interesting program has been arranged by a joint committee of the two societies:

Monday, May 8

"Histaminic Cephalgia."—Bayard T. Horton, M. D., Rochester, Minnesota. (Open discussion).

"Cataract Wound Closure with 6-0 Absorbable Gut." —Bruce Fralick, M. D., Ann Arbor, Michigan. (Discussion by Harry V. Thomas, M. D., Clarksburg).

"Rhinological Aspects of Chronic Dacryocystitis."—President's address (Virginia), Francis P. McGovern, M. D., Danville.

"The Selection of Surgery of the Vertical Muscles." —William P. McGuire, M. D., Winchester.

"Implantation Cyst of the Conjunctiva (Case Report)."—Edward W. Perkins, M. D., Richmond.

"Dacryocystorhinostomy."—Arthur C. Chandler, M. D., Charleston. (Discussion by Ivan Fawcett, M. D., Wheeling.

Tuesday, May 9

"Diseases and Treatment of the Hard and Soft Palate."—Fred Dixon, M. D., Cleveland. (Discussion by Sobisca S. Hall, M. D., Clarksburg).

"Ocular Therapeutic Principles and Practical Application."—Edwin B. Dunphy, M. D., Boston. (Open discussion).

"Nasal Allergy"—Frederick C. Reel, M. D., Charleston. (Discussion by R. M. Ferrell, M. D., Lewisburg).

"The Endaural Approach for Surgery of the Mastoid and Temporal Bone Technique and Advantages."—Houston L. Bell, M. D., Roanoke.

The annual banquet will be held Monday evening at eight o'clock, and the members of the West Virginia Academy will be host at a cocktail party preceding the banquet. A golf tournament has been arranged, and awards will be made at the banquet.

The executive council of the Virginia Society and the West Virginia Academy will meet separately on Sunday evening, May 7, and the annual business meeting of each group will be held Tuesday morning at eight-thirty o'clock.

Dr. Francis P. McGovern, of Danville, is president of the Virginia Society, and the West Virginia Academy is headed by Dr. Garnett P. Morison, of Charles Town.

HEALTH OFFICERS ASSOCIATION ORGANIZED

At the combined staff conference sponsored by the State Department of Health, held in Charleston, March 10, 1950, the Health Officers Association of West Virginia was formally organized, and Dr. Guy R. Post, director of the Wood-Parkersburg Health Department, was named president.

Dr. J. M. Coram, of Beckley, part-time health officer, was elected vice president; Dr. Luke W. Frame, director of the Cabell-Huntington Health Department, secretary; and Dr. R. M. Dodrill, of Weston, district health officer, treasurer.

It is planned by officers of the new association to have meetings periodically for the discussion of health problems.

DOCTOR'S WIDOW "MOTHER OF THE YEAR"

For the third consecutive year, the widow of a doctor has been named West Virginia's "Mother of the Year." The selection of Mrs. James C. Dunbar, of Gauley Bridge, for this honor has been announced by Mrs. Dale Thomas, of Charleston, chairman of the West Virginia American Mothers Committee of the Golden Rule Foundation, created for the purpose of recognizing some state mother for this honor.

Mrs. Dunbar is a native of Nicholas county. She attended Summersville normal school and the American School for Nurses in Chicago. Although 73 years of age, she is still active as a midwife and has delivered over 1200 babies.

Her late husband, Dr. James C. Dunbar, was licensed in West Virginia in 1896 and practiced in Nicholas county until his death several years ago.

In 1949, Mrs. F. H. Brown, widow of the late Dr. F. H. Brown, was chosen for this honor. She is also a native of Nicholas county, but has resided in Morgantown since 1945.

Mrs. J. M. Myers, of Philippi, widow of the late Dr. J. M. Myers, of that city, was West Virginia's candidate for "Mother of the Year" in 1948.

In 1949, Mrs. Dunbar was selected by the local post of the American Legion as the outstanding citizen of the community. She will be a contestant for the title of "American Mother of 1950," and, if elected, will be invited to take part in the golden rule observance on Mother's Day in New York City.

IMPORTANT TO REPORT CHANGE OF ADDRESS

A comparatively new regulation of the post office department provides that when a publication is undeliverable because of a local change of address, the copies are to be delivered to the new address without charge until two successive issues have been published, and a card (Form 22-S) is to be furnished to the subscriber at his new local address with the request that it be used promptly to notify the publisher of a change in address.

If copies bearing the old address continue to be received after the period prescribed has elapsed, the carrier is to write the new address on the copies and return them to the postmaster, who attaches to the copy a form showing the new address, and the publication is then returned to the publisher.

This explanation is made because recently copies of the Journal addressed to several different members of the State Medical Association have been returned to this office because they were sent to the old address.

It is important that every doctor receiving the Journal notify the West Virginia Medical Journal immediately when there is a change in local address. Changes in address by reason of relocation in some other city in or out of the state should also be reported without delay.

LICENSE REVOKED

The license of Dr. William Mitchell Lewis, of Huntington, has been revoked by the medical licensing board on account of his conviction on a felony charge.

RURAL HEALTH CONFERENCE IN MAY

A statewide Rural Health Conference, sponsored by the West Virginia State Medical Association with the full support of the State Department of Health and the Agricultural Extension Service of West Virginia University, will be held May 18, at the State 4-H Camp at Jackson's Mill.

Representatives of all farm organizations in the state have been invited to attend the meeting, and it is expected that most of the county agents, home demonstration agents, and couny health officers and nurses will be present.

Other groups which will be represented at the meeting include the State Nurses' Association, the State P. T. A., medical and hospital service plans, and UMW Welfare and Retirement Fund. Dental, pharmaceutical, and hospital groups will also participate.

The program will get under way at 10:00 A. M., with Dr. Frank J. Holroyd, of Princeton, chairman of the state public relations committee, presiding as chairman. There will be three speakers on the program, two in the morning and one in the afternoon. The speakers will sit as a panel at a roundtable discussion in the afternoon.

Members of all groups present at the meeting will be guests of the State Medical Association at a luncheon at noon which will be served in the Mount Vernon dining hall.

At the afternoon session, Miss Gertrude Humphreys, state leader, home demonstration work, Agricultural Extension Service, will submit a report concerning a survey of available medical services in a typical rural county in this state. This survey has just been completed.

Dr. Henry B. Mulholland, of Charlottesville, professor of practice of medicine and assistant dean of the University of Virginia Medical School, and Dr. George F. Bond, of Bat Cave, North Carolina, head of the Valley Clinic and Hospital, have already accepted invitations to appear on the program.

Doctor Mulholland, who is well known in West Virginia, is chairman of the Virginia Council on Health and Medical Care, and a member of the Council on Medical Service and the Committee on Rural Medical Service of the American Medical Association.

Doctor Bond has done outstanding work in providing medical care for the people of his home community. The Valley Clinic and Hospital was built and is being maintained almost solely by funds provided locally.

LARGE ATTENDANCE AT GREENBRIER MEETING

More than 140 doctors from Virginia and West Virginia attended the interstate medical meeting held at the Greenbrier, White Sulphur Springs, March 29, sponsored jointly by the Alleghany-Bath Medical Society (Virginia) and the Greenbrier Medical Society.

The success of this first joint meeting between the two societies has been followed by the discussion of plans to make it an annual event, but no definite decision has yet been reached. A meeting of the advisory council of the Greenbrier Clinic was held concurrently with the interstate medical meeting.

USE OF FEDERAL FUNDS FOR FOUR-YEAR SCHOOL TO BE STUDIED BY COMMITTEE

A special five-member subcommittee has been appointed by Senate President W. Broughton Johnston, of Princeton, and House Speaker W. E. Flannery, of Logan, co-chairmen of the legislative interim committee on four-year school of medicine and dentistry for the purpose of investigating the possibility of obtaining federal aid for construction of a four-year school in West Virginia.

The committee, which will explore every avenue to find financial aid for the construction of the school, is headed by Dr. Irvin Stewart, president of West Virginia University. The other members of the group are Dr. N. H. Dyer, state director of health; Dr. E. J. Van Liere, dean of West Virginia University School of Medicine; Dr. Donzie Lilly, Princeton, immediate past president of the West Virginia Dental Society; and Dr. Ward Wylie, Mullens, member of the state senate from the ninth senatorial district.

Dr. Herman G. Weiskotten, dean of Syracuse University College of Medicine, and Dr. Wilburt C. Davison, dean of Duke University School of Medicine, attended a meeting of the interim committee at Charleston on March 29. Members of the special advisory committee appointed by the Governor were also present. It was stated at that time that a report of the study that has been made by the two deans would be submitted within a few weeks.

Besides President Johnston and Speaker Flannery, the legislative interim committee is composed of Senators Don J. Eddy, Monongalia County; Dr. Ward Wylie, Wyoming; A. L. Reed, Preston; and Theodore M. Bowers, Wetzel. The House of Delegates is represented by Mrs. Nell W. Walker, Fayette; Robert E. Roach, Hancock; H. Hayden Morgan, Upshur; and J. Allen Overton, Wood.

The Advisory Committee named by Governor Okey L. Patteson is composed of Dr. Irvin Stewart, Morgantown, president of West Virginia University; Dr. Thomas G. Reed, Charleston, chairman of the Council of the State Medical Association; Dr. W. W. Curry, Holden, immediate past president of the West Virginia Dental Society; and Miss Leoda Neininger, R. N., president of the state nurses association, all ex-officio members; Miss Martha Wooddell, R. N., of Clarksburg, immediate past president of the State Nurses Association; Clarence Martin, attorney, Martinsburg; Dr. Donzie Lilly, of Athens, past president of the State Dental Society; Dr. D. A. MacGregor, of Wheeling, chairman of the State Medical Association's Fact Finding and Legislative Committee; Dr. Thomas Bess, of Keyser, past president of the State Medical Association; and Mr. John T. Johnson, of Williamstown, master of the West Virginia State Grange.

Besides studying the advisability of the establishment of a four-year school of medicine and dentistry, the interim committee survey will also include the study of the matter of location.

The resolution setting up the committee empowers the members to call upon any departments of the state government for detailed information, and the committee is authorized to summon witnesses and take testimony if deemed necessary.

PROGRAM COMPLETED FOR ANNUAL HEALTH CONFERENCE AT WHEELING

The 26th Annual State Health Conference will be held at the McLure Hotel, in Wheeling, May 4-5, 1950.

The first general session is scheduled to open at 9:30 A. M., Thursday, May 4, with Dr. N. H. Dyer, state director of health, presiding. Hon. Carl G. Bachmann, Mayor of Wheeling, will deliver the address of welcome, after which the following program will be presented:

"Health Protection for All."—Haven Emerson, M. D., Member of the Board of Health of the City of New York, and Emeritus Professor of Public Health Practice, Columbia School of Public Health, New York City.

"The Local Board of Health."—L. E. Burney, M. D., State Health Commissioner, Indiana State Board of Health, Indianapolis, Indiana.

"Selling Health to the Community."—Mrs. Blanche R. Miller, Director, Health Education, Cincinnati Anti-Tuberculosis League, Cincinnati, Ohio.

The second general session is scheduled for Friday afternoon at two o'clock with O. R. Lyons, president of the West Virginia Public Health Association, presiding. The following program will be presented at this session:

"Community Mental Health is Everybody's Job."—Miss Frances Williams, Mental Health Nursing Consultant, New York City Health Department.

"Providing Public Health Training for West Virginia."—F. J. Holter, Ph.D., Professor of Physical Education Graduate Advisor, West Virginia University, Morgantown.

"Measurement in Public Health—The Yardstick or the Slide Rule."—Albert Bailey, Ph.D., Special Assistant, Federal Security Agency, public health service, Washington, D. C.

Section meetings are scheduled for Thursday afternoon and Friday morning, and there will be a banquet at the McLure Hotel, Thursday evening. The annual conference party will be held at the American Legion Hall Friday evening at nine o'clock.

FILM REVIEW BOOKLET AVAILABLE

The booklet, "Reviews of Medical Motion Pictures," has been revised and issued as a second edition by the American Medical Association. The booklet contains reprints of reviews of over 200 medical and health films appearing in the Journal of the American Medical Association during 1950. Each film is indexed according to subject matter.

The purpose of the reviews is to provide description and evaluation of motion pictures which are available to the medical profession.

Copies of the booklet may be obtained from the Order Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

A list of films available through the American Medical Association motion picture library will be mailed upon request.

MLB TO MEET JULY 10-12

The summer meeting of the Medical Licensing Board will be held at the Capitol, in Charleston, July 10-12, for the purpose of examining applicants for licensure to practice in West Virginia.

CONVENTION PROGRAM COMPLETED

A special conveniton bulletin will be mailed to each member of the West Virginia State Medical Association late in April. Full information will be furnished in the bulletin concerning room reservations at the Greenbrier and other hotels in White Sulphur Springs for the 83rd annual meeting, July 27-29.

The program committee has completed the scientific program for the three-day meeting. The committee is composed of Dr. J. P. McMullen, of Wellsburg, and Drs. E. J. Van Liere, of Morgantown, and R. E. Flood, of Cove Station, Weirton.

Arrangements are now being made for meetings of sections and affiliated societies and associations. All meetings with the exception of general sessions will be held the afternoon of each day of the convention.

No facilities are available for scientific and technical exhibits and this part of the program has had to be omitted for the second consecutive year.

Assurances have been received at the headquarters offices of the State Medical Association that the management of the Greenbrier and the other hotels in White Sulphur Springs will make every effort to find suitable accommodations for all members of the Association and their wives who wish to attend the convention.

Full information concerning the interesting program that has been arranged will appear in the June and July issues of the West Virginia Medical Journal.

SAN FRANCISCO MEDICAL GOLF TOURNAMENT

The 34th annual tournament of the American Medical Golfing Association will be held on the two attractive golf courses of the Olympic Golf Club, San Francisco, Monday, June 26, the opening day of the 1950 meeting of the American Medical Association. Fellows planning to participate in the tournament should send their name, address, and section in which they were registered to Bill Burns, Secretary, 2020 Olds Tower, Lansing 8, Michigan.

The starting committee will assist players from the different states to arrange games with like handicaps, age, and specialty. The detailed program of the tournament will appear in the convention number of the Journal of the American Medical Association. Applications for membership in the American Medical Golfing Association may be obtained by writing to the secretary.

NEW SUPERINTENDENT AT SPENCER

Dr. Thomas S. Knapp has been appointed by Gov. Okey L. Patteson as superintendent of Spencer State Hospital. He has been serving as acting superintendent since January 5, 1950. He succeeds Dr. C. E. Hamner, who resigned early in the year to return to Columbus, Ohio, to accept a position on the medical staff of the Columbus State Hospital.

Doctor Knapp is a graduate of West Virginia University and received his M. D. degree from Jefferson Medical School, Philadelphia. He was formerly on the staff of McGuire Hospital in Richmond and served two years as a psychiatrist in the medical corps of the army during World War II.

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OBITUARIES

PAUL LOWELL DOUGLAS, M. D.

Dr. Paul Lowell Douglas, 40, of Pursglove, died April 17, 1950, as the result of bullet wounds alleged to have been inflicted by a former patient. He was shot in the neck while in his car at the entrance to the Monongahela river ferry at Star City, near Morgantown. He got out of his car and was shot twice again, death being instantaneous.

Doctor Douglas was born at Langdon, Missouri, and received his A. B. degree in 1933 from William Jewell College. He received his M. D. degree in 1939 from Washington University School of Medicine, St. Louis. He served his internship at Ohio Valley General hospital, in Wheeling, 1940-1941, after which he enlisted in the Medical Corps of the Army, serving for over five years.

In 1946, Doctor Douglas was licensed to practice in West Virginia by reciprocity with Missouri, and located at Pursglove, where he engaged in industrial practice until his death.

He was a member of the Monongalia County Medical Society, the West Virginia State Medical Association, and the American Medical Association. He is survived by his widow and a small son.

JOHN EWING HUGHART, M. D.

Dr. John Ewing Hughart, 75, of Fayette County, died March 31, 1950, at his home at Hilton Village. Doctor Hughart was born at Warm Springs, Virginia, son of the late James Perry Hughart and Mary Jane (McCutchan) Hughart. He received his M. D. degree in 1904 from the Medical College of Virginia, Richmond, and located for the practice of medicine that same year in Fayette county.

Doctor Hughart was engaged in practice at Landisburg, Fayette county, from 1917 until 1941, when he moved to Hilton Village.

He was a former member of the Fayette County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

* * * *

ROBERT SHANNON PECK, M. D.

Dr. Robert Shannon Peck, 61, of Cannelton, died March 24, 1950, in a hospital at Montgomery. He had been ill for many months with diabetes.

Doctor Peck was born in Hinton, attended public schools there, and received his M. D. degree in 1915 from the College of Physicians and Surgeons, Baltimore. He located at Powellton that same year, but moved to Hinton in 1916. In 1921 he located at Cannelton, where he remained in active practice until 1948 when he was compelled to retire on account of illness.

He was a member of the Fayette County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

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He is survived by his widow, the former Cecilia Marie Thorson, of Hinton; two sons, Dr. DeWitt Peck, of Montgomery, and Dr. Clemmer M. Peck, of Powellton; and three daughters, Mrs. Anita Romig, of Cleveland, Ohio, Mrs. Gloria Jacobson, of Los Angeles, and Miss Cecilia Peck, of Cannelton.

* * * *

HOWARD H. VEON, M. D.

Dr. Howard H. Veon, 70, of Parkersburg, died February 22, 1950, in a hospital in that city. He had been ill for about three weeks.

Doctor Veon was born at Burning Springs, West Virginia. After completing his academic training at West Virginia University, he enrolled at Ohio State University School of Medicine and received his M. D. degree there in 1902. At the completion of his internship, he did postgraduate work at Tulane University School of Medicine, Chicago Polyclinic and Philadelphia Polyclinic. He located at Richwood, where he served as chief surgeon at Sacred Heart hospital for several years. He moved to Parkersburg in 1926 and engaged in the practice of his specialty of EENT until his last illness.

Doctor Veon had served a term as mayor of Richwood.

Besides his widow, the former Florence (Ellison) Veon, he is survived by three sisters, Mrs. Anna B. Craig and Mrs. Emma Phillips, of St. Mary's, and Mrs. Nellie Armor, of Marietta.

BOOK REVIEWS

PROCEEDINGS OF THE FIRST CLINICAL ACTH CONFERENCE—Edited by John R. Mote, M. D., Medical Director, Armour Laboratories. Pp. 624, with 414 illustrations. The Blakiston Company, Philadelphia. 1950. Price $5.50.

There are few men competent to review critically a volume of such technical detail and wide implication. The effects of the adrenocorticotrophic hormone on a wide variety of diseases, rheumatic allergic, endocrine, malignant, infectious, neurologic and others, are presented with a wealth of biochemical measurements. All told, a total of 613 cases were observed in fifty medical centers in this country and Canada.

These reports bring hope for some of our at present hopeless diseases. It is true that most of the series prescribed are very small and that the possible toxic effects of ACTH are not as yet certainly known. But, we may hope that from these many sources will come, in time, a tried and useful weapon for those of us who deal directly with diseases and who necessarily must be free from the encumbrances of complicated laboratory measurements.—Frederick R. Whittlesey, M. D.

I often wonder why we could not have as intelligent a campaign against alcoholism as we have against cancer, polio, and heart disease.—J. F. in Ohio St. Med. J.

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COUNTY SOCIETIES

BARBOUR-RANDOLP-TUCKER

Dr. DeWitt James Lowell was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker Medical Society, held March 16, at Elkins. His subject was, "Radioactive Isotopes, Tagged Elements and Their Importance in Research and Treatment."

Preceding the scientific program at Elkins, a business meeting of the society was held at the Main Street Restaurant in Parsons, where dinner was served to the members present.

Dr. Karl Myers submited a report for the public relations committee, and distributed packaged PR material to the members. Dr. Guy H. Michael, a member of the state PR committee, reported that efforts are being made to arrange a radio address for the Elkins area on the subject of Socialized Medicine.

The president, Dr. C. L. Leonard, urged all present to contact local groups with reference to the adoption of resolutions opposing compulsory health insurance.

The following cancer committee was appointed by the president: Drs. Hu Myers, Guy H. Michael, and R. V. Cortin.—Donald R. Roberts, M. D., Secretary.

* * * *

FORT HENRY ACADEMY

Dr. Joe Vincent Meigs, clinical professor of gynecology at Harvard University Medical School and advisory editor of "Monographs on Surgery," was the guest speaker at the meeting of the Fort Henry Academy of Medicine, held March 28, at the Wheeling Hospital School of Nursing auditorium, in Wheeling. His subject was, "Practical Gynecology." The paper was discussed by Dr. Wilda S. Joseph and Dr. Earl S. Phillips, both of Wheeling.

The meeting was attended by a large group of doctors and nurses practicing in the Wheeling area.—Robert M. Sonneborn, M. D., Secretary.

* * * *

MERCER

Dr. Bernard Krug, of Alexandria, Virginia, medical director of the eastern division, American Red Cross, and Mr. Charles Lively, executive secretary, West Virginia State Medical Association, were guest speakers at the regular monthly dinner meeting of the Mercer County Medical Society, held March 20, at Pete's Grill, in Bluefield.

Doctor Krug presented a detailed report concerning the Red Cross Blood Bank program, and Mr. Lively discussed the part that the Mercer County Medical Society has played and is playing in state and national medical programs.

At a business meeting following the program, it was ordered that the society be incorporated.

Dr. Hampton St. Clair, the president, who presided at the meeting, appointed a committee to meet with the Bluefield Ministerial Association for the purpose of discussing mutual problems. The committee is composed of Drs. O. G. King, Upshur Higginbotham,

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Richard C. Neale, E. Lyle Gage, H. C. Davis, C. J. Reynolds, Robert Gatherum, and J. Francke Fox.

The society also went on record as being in favor of an adequate county health unit.

Following a request received from Dr. Philip W. Oden, president of the state cancer committee, Doctor St. Clair announced the appointment of Drs. C. T. St. Clair, Jr., J. Richmond Lowe, and Charles M. Scott as members of the local cancer committee.

Drs. Charles M. Scott and E. Lyle Gage, co-chairmen of the public relations committee, were directed to prepare a medical press-radio code for consideration by the Council of the West Virginia State Medical Association.—Frank J. Holroyd, M. D., Secretary.

* * * *

MINGO

Dr. J. B. Poindexter, oral surgeon of Huntington, was the guest speaker at the regular monthly meeting of the Mingo County Medical Society, held March 16, at the Mountaineer Hotel in Williamson. His subject was, "Teeth as a Foci of Infection." Several local dentists and pharmacists were present as guests of the society.

Plans for the establishment of a cancer detection clinic, to be located in Williamson, were discussed by several members of the society, and a report was submitted concerning the proposed telephone secretarial service for members. It was announced that the members of the Memorial Hospital staff had agreed to the use of the hospital switchboard for this service.

Dr. J. C. Lawson, the president, appointed the following Committee on Industrial Medicine: Drs. Robert C. Lawson, John E. Caton, and E. T. Drake. Doctor Lawson will serve as chairman of the committee.—E. T. Drake, M. D., Secretary.

* * * *

PARKERSBURG ACADEMY

Dr. J. Mason Hundley, professor of Gynecology, University of Maryland School of Medicine, Baltimore, was the guest speaker at the regular monthly meeting of the Academy of Medicine of Parkersburg, held April 6, at the American Legion Home in Parkersburg. His subject was, "Carcinoma of the Generative Tract." His interesting address was illustrated with lantern slides.

At the business meeting following the scientific program, the society voted to support the American Red Cross blood bank program now being organized with a center in Huntington.

Dr. Shirley M. Prunty, of Parkersburg, was elected to honorary membership in the society.—S. William Goff, M. D., Secretary.

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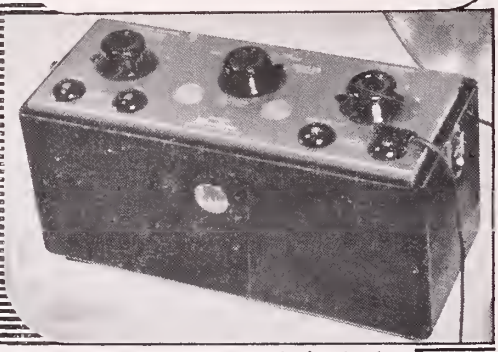

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WOMAN'S AUXILIARY

CABELL

The regular monthly meeting of the Woman's Auxiliary to the Cabell County Medical Society was held March 14 at the home of Mrs. C. Stafford Clay, in Huntington. At the business meeting, Mrs. Gates Wayburn presided, and the principal item of business was the submission of a report by the nominating committee. A dessert hour honoring new members was enjoyed at the conclusion of the business meeting.—Mrs. Melvin W. McGehee, Editorial Chairman.

* * * *

EASTERN PANHANDLE

Mrs. Ernest Bitner, of Martinsburg, was elected president of the Woman's Auxiliary to the Eastern Panhandle Medical Society at the annual meeting held March 8, at the home of Mrs. William L. Haltom, in Martinsburg.

Mrs. R. E. Clapham was elected vice president, Mrs. William L. Haltom, recording secretary, Mrs. Richard B. Talbott, treasurer, and Mrs. George O. Martin, historian.

The proposed revision of the constitution and by-laws will be submitted to a vote of the members at the regular quarterly meeting in May.—Mrs. John H. Kilmer, Corresponding Secretary.

* * * *

HARRISON

Mrs. Richard K. Hanifan, of Clarksburg, was elected president of the Woman's Auxiliary to the Harrison County Medical Society at the regular monthly meeting held April 6 at the YWCA, in Clarksburg. Other officers were elected as follows: President elect, Mrs. Thomas V. Gocke; vice president, Mrs. James E. Wilson, Jr.; secretary, Mrs. E. Burl Randolph; and treasurer, Mrs. Andrew J. Weaver.

Mrs. J. E. Stephenson, the retiring president, presided at the meeting.

Following the meeting, a tea was held honoring the nurses of the graduating classes of the Union Protestant and St. Marys Hospital Schools of Nursing, as well as students in local high schools who have expressed an interest in nursing as a career.—Mrs. James E. Wilson, Jr., Secretary.

* * * *

KANAWHA

Mrs. P. A. Tuckwiller was elected president of the Woman's Auxiliary to Kanawha Medical Society at the regular monthly meeting held April 18, at the Daniel Boone Hotel in Charleston. She succeeds Mrs. William A. Thornhill.

Mrs. Duke A. Dent was elected first vice president, Mrs. W. Paul Elkin, second vice president, Mrs. Newman H. Newhouse, third vice president, Mrs. A. B. Curry Ellison, recording secretary, Mrs. John C. Condry, corresponding secretary, and Mrs. Arkie B. Bowyer, treasurer. Mrs. Charles E. Staats was named president elect.

The new officers will be installed at the regular monthly meeting in May.

The society went on record unanimously as opposing compulsory health insurance, and it was ordered that the usual annual contribution be made to the Jane Todd Crawford Memorial Fund.—Mrs. V. L. Peterson, Corresponding Secretary.

* * * *

MARION

Dr. O. L. Haynes, of Fairmont, and Mr. Robert Gross, representing the American Legion, were guest speakers at the February dinner meeting of the Woman's Auxiliary to the Marion County Medical Society. Doctor Haynes discussed Rheumatic Heart Disease, and Mr. Gross reported concerning the heart campaign in Marion county.

"Doctor's Day" was observed March 11 by the Woman's Auxiliary to the Marion County Medical Society at a dinner meeting held at the Fairmont Field Club. The tables were decorated with spring flowers and greenery.

A pre-dinner entertainment program was presented by Mesdames E. D. Wise, W. A. Welton, John P. Helmick and C. M. Ramage. Introduced as the "Auxiliary Troubadors", they presented a most interesting musical program featuring an accordian, guitar and harmonica.

Many games were played during the evening and suitable prizes awarded the winners. The social committee included Mesdames George H. Traugh, L. Rush Lambert, Joe Yost, Jr., J. R. Tuckwiller, George T. Evans, and S. W. Parks.

The committee on arrangements was composed of Mesdames O. L. Haynes, R. W. Powell, Earl L. Kinney, and William T. Lawson.

The membership chairman, Mrs. George T. Evans, announced the election of Mrs. R. W. Powell, Mrs. A. Glenn Evans, Mrs. William Ehrgott, and Mrs. Earl R. Kinney to membership in the Auxiliary.—Mrs. William T. Lawson, Secretary.

* * * *

PARKERSBURG ACADEMY

The Woman's Auxiliary to the Academy of Medicine of Parkersburg was hostess to the executive board of the Auxiliary to the West Virginia State Medical Association at the spring meeting held April 11 at the Chancellor Hotel in Parkersburg.

Mrs. Dana T. Moore, of Parkersburg, president of the State Auxiliary, presided at the board meeting at which plans were formulated for the 26th annual meeting at White Sulphur Springs, July 27-29.

Mrs. Seigle W. Parks, of Fairmont, was appointed recording secretary to succeed Mrs. J. H. Murry, of Kimball, who resigned on account of ill health.

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Personal Course in General Surgery, Two Weeks, starting September 25.
Surgery of Colon & Rectum, One Week, starting May 15, June 5.
Esophageal Surgery, One Week, starting June 5.
Breast & Thyroid Surgery, One Week starting June 26.
Thoracic Surgery, One Week, starting June 12.
Gallbladder Surgery, Ten Hours, starting June 19.
Fractures & Traumatic Surgery, Two Weeks, starting June 12.
Basic Principles in General Surgery, Two Weeks, starting September 11.
GYNECOLOGY—Intensive Course, Two Weeks, starting June 19, September 25.
Vaginal Approach to Pelvic Surgery, One Week, starting May 15.
OBSTETRICS—Intensive Course, Two Weeks, starting June 5, September 11.
PEDIATRICS—Personal Course in Cerebral Palsy, Two Weeks, starting July 31.
Personal Course in Diagnosis & Treatment of Congenital Malformations of the Heart, Two Weeks, starting June 5.
MEDICINE—Intensive General Course, Two Weeks, Starting October 2.
Electrocardiography & Heart Disease, Two Weeks, starting July 17.
Hematology, One Week, starting May 8.
Gastro-enterology, Two Weeks, starting May 15.
Liver & Biliary Diseases, One Week, starting June 5.
Gastroscopy, Two Weeks, starting May 15, June 12.
DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.
UROLOGY—Intensive Course, Two Weeks, starting September 25.
Cystoscopy, Ten Day Practical Course, every two weeks.

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The Marion County Auxiliary presented a memorial to Mrs. A. H. Stevens, originator of the point system, which was accepted by the executive board. The memorial is in the form of an award of $5.00 to be presented to the local Auxiliary with a membership not to exceed thirty-nine having the highest number of points. The award is to be made each year at the annual meeting.

At the conclusion of the business meeting, the members of the executive board were guests of the local auxiliary at the regular luncheon meeting at the Chancellor Hotel. Guests included Mrs. Ross P. Daniel, president elect of the State Auxiliary, and Mrs. W. E. Hoffman, third vice president of the Auxiliary to the American Medical Association.

Short addresses were delivered by Dr. Frank J. Holroyd, of Princeton, who related humorous incidents in the current PR campaign; Dr. Charles E. Watkins, of Oak Hill, president of the State Medical Association, who stressed the importance of work by the Auxiliary membership; and Mr. Charles Lively, executive secretary of the West Virginia State Medical Association, who gave a preview of the forthcoming 83rd annual meeting at White Sulphur Springs.

Mrs. M. A. Santer, retiring president, presided at the luncheon and at the business meeting which followed.

Mrs. Fred Potter announced that plans had been completed for the annual Student Nurses' Fund benefit dance to be held April 30.

Officers for the ensuing year were elected as follows: President, Mrs. W. W. Davis; first vice president, Mrs. Wayne Bronough; second vice president, Mrs. Richard Sheridan; recording secretary, Mrs. Ralph H. Boice; corresponding secretary, Mrs. S. William Goff; and treasurer, Mrs. James C. Batten.—Mrs. Paul L. McCuskey, Corresponding Secretary.

* * * *

RALEIGH

More than 150 guests attended a tea sponsored by the Woman's Auxiliary to the Raleigh County Medical Society, held March 20, at the Woman's Club, in Beckley. The object of the tea was to stimulate and promote the local nurses' retirement program.

The principal address was delivered by Mrs. L. G. Houser, who explained the requirements and advantages of the nurses' training program.

A musical program was presented by Mrs. Wallace B. Lilly and Mrs. W. G. Moran, Jr. In the receiving line were Mesdames Ross P. Daniel, R. G. Broaddus, Clyde A. Smith, and Dudley C. Ashton. Mesdames S. A. Ford, D. B. Jarrell, D. D. Daniel, and W. C. Covey presided at the tea table.

Guests present included the registered nurses at the Raleigh General Hospital, the Beckley Hospital, and Pinecrest Sanitarium; student nurses from the Raleigh General Hospital; and girls from the local high schools who have expressed an interest in the nursing profession.—Mrs. L. M. Halloran, Secretary.

It has been said that medicine like music speaks a universal language. Can it be that the medical profession holds, in part with other factors, the amulet to world peace and good will?—Charles H. Sprague, M. D., in Conn. St. Med. J.

CORRESPONDENCE

AMERICAN MEDICAL ASSOCIATION
Scientific Assembly
SECTION ON OBSTETRICS AND GYNECOLOGY
James R. Bloss, M. D., Chairman
Huntington, W. Va.

April 17, 1950

Mr. Charles Lively
West Virginia State Medical Association
Box 1031, Charleston 24,
West Virginia

Dear Charlie:

I have been somewhat remiss in not writing to thank you for having secured the reprints (National Education Campaign material) for me. They came about three weeks ago. I have been presenting them to my private patients here in the office, with the request that they read the material. I have talked this matter of Social Security and Governmental Medical Service over with them and find some very encouraging results.

Of the approximately two hundred persons with whom I have discussed this matter there has been only one who seemed to feel that Government Medicine would be a good thing. Without exception, I would say that 90 per cent of the others who have given any thought to the question are opposed to it. All of them, however, are apparently in favor of voluntary plans for helping to pay hospital and professional service bills.

I cannot help but feel that physicians can accomplish a tremendous lot by this personal approach to the problem, in dealing with the patients as individuals. It seems to me that we can do more when we have an opportunity to talk to them alone. At any rate that is the way I am doing it. I hope that it will be of some help.

Again, thanks for obtaining the reprints for me, and I hope I am helping. All good wishes, as always.

Sincerely,

(Signed) James R. Bloss, M. D.

* * * *

WORKMEN'S COMPENSATION FUND
Charleston, West Virginia

April 14, 1950

Mr. Charles Lively, Secretary
West Virginia State Medical Association
Atlas Building
Charleston, West Virginia

Dear Mr. Lively:

The Department has had numerous complaints from the subscribers to the Workmen's Compensation Fund about the high prices being paid for drugs used in the treatment of compensation patients.

We have made a careful study of the cost of these drugs to the doctors and in arriving at a fee, we have

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set it sufficiently high to allow a fair profit for the handling of these drugs.

This Department will not pay beyond $.50 per hundred thousand units for penicillin, duracillin, crystiicillin, or parencillin. We will pay $1.25 per gram for streptomycin. We will pay for aureomycetin and chloromycetin at the rate of $.80 for the 250 mg. capsule and $.25 for the 50 mg. capsule.

Yours very truly,

T. E. Cline,
Office Director,
Medical Division.

* * * *

Civilion Personnel Division
ARMY CHEMICAL CENTER
Edgewood, Maryland

30 March 1950

Mr. Charles Lively, Executive Secretary
State Medical Association of West Virginia
Charleston 24, West Virginia

Dear Mr. Lively:

The services of several Medical Officers, GS-12, salary beginning at $6400 per annum with overtime paid for all hours worked over 40 in basic work week, are critically needed at this installation. It is hoped that your office may be able to give us some assistance in this connection. The minimum qualifications are as follows:

EDUCATION: Must be graduates of a medical schools of recognized standing with the degree of doctor of medicine. Applicants who are qualified in all other aspects but who are graduates of schools classified as "C" or "unapproved" by the American Medical Association, will be considered provided education has been supplemented with at least one year in the military service or the U. S. Public Health Service, with unrestricted duties as commissioned medical officer such duties including the treatment of patients.

LICENSE: Applicants must be currently licensed to practice medicine and surgery in a state or territory of the United States. This requirement will be waived for retired medical officers of the regular Medical Corps of the Army, Navy, or the U. S. Public Health Service.

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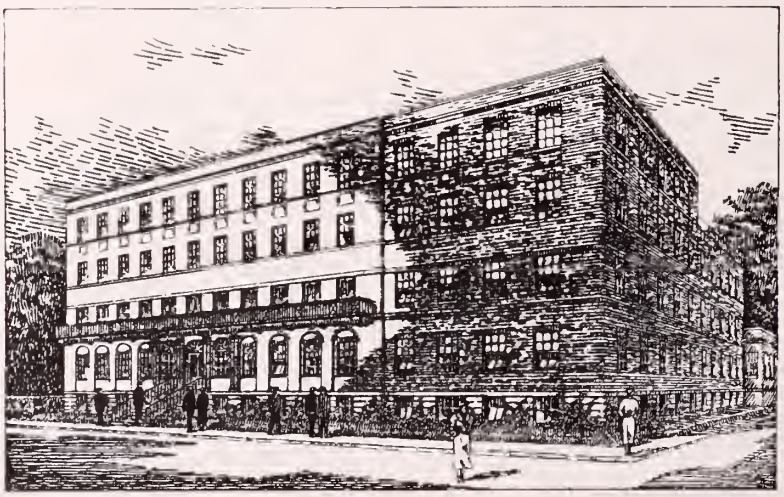

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Bachelor Officer's Quarters will be made available for those requiring them and every effort will be made to obtain housing for applicants with families.

Interested persons may report to the Employee Utilization Branch, Civilian Personnel Division, Building No. 219, Army Chemical Center, Edgewood, Maryland, between 8:00 a. m. and 2:00 p. m., except Saturday, Sunday or holidays or contact this office by mail in order that an interview may be arranged. Attached are applications which it is requested applicants com-

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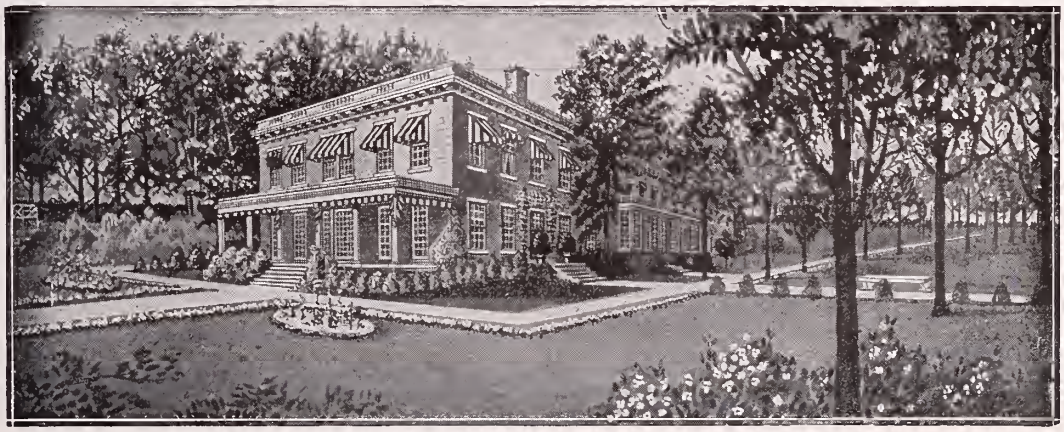

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Very truly yours,

J. F. Moats,
for: D. K. Evans, Chief
Employee Utilization Branch,
Civilian Personnel Division

"SUFFOCATION" IN INFANCY

Deaths from "accidental suffocation" are mostly concentrated in the first six months of life. In both Britain and the U.S.A. the peak age-incidence is in the second and third months; in the first month the incidence is much lower. This age-distribution seems incompatible with accidental suffocation, since infants are most helpless during their early weeks and have become quite vigorous by the third month.

The assumption that infants are easily suffocated is untenable, for all except very young and feeble infants react vigorously to a feeling of impending suffocation and certainly do not allow themselves to be asphyxiated by turning their face to a pillow. Moreover, deaths from "accidental suffocation" have an age and seasonal incidence corresponding closely with the incidence of acute respiratory infection.

The coroner should insist on a complete pathological and bacteriological investigation in all cases of suspected suffocation in infancy, in the interests not only of statistical accuracy but also of the bereaved parents. and Smith suggests that the coroner might always be asked to grant time for histological studies.

A diagnosis of accidental suffocation can amount to a life sentence of self-reproach for the parents, and it should be made only in those rare instances where the clinical and pathological evidence is incontrovertible.—The Lancet.

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A TRIBUTE TO THE AMA

The American Medical Association merits pharmacists' warmest commendation for setting up a mobile press bureau which will travel to many of the larger cities for the purpose of giving the people its views on compulsory national health insurance and other timely issues bearing upon the adequacy of medical care.

It is our conviction that the Truman-Ewing scheme for the socialization of medicine will die on the vine once the AMA is seen in the light of its vitally important contributions to public health.

The Association, its critics to the contrary, is most progressive in its attitude toward medical education, hospital expansion, therapeutic research, and the many other forces and factors which underlie our splendid system of private medical practice.

The AMA needs to tell the people just why it opposes the Truman-Ewing scheme. It needs to warn that such a scheme will drastically lower the standards of medical care.

It should be pointed out, too, that the socialization of medicine will witness the frustration of medical progress. Professional incentive will tend to fade out under the blight of political control.

Such results are inevitable once the state supplants the physician as the central figure in medical care. The AMA needs only to point to the demoralization of medical services in Britain as proof of what will happen here, should Congress force the incredible Truman-Ewing scheme upon the American people.

The AMA is well serving the public interest by opposing the nationalization of medical services.—Drug Topics.

ACTH AND CORTISONE

We will need to change many of our concepts of certain diseases if cortisone and adrenocorticotropin (ACTH) live up to the expectations of present clinical evidence. From the reports to date, there has been nothing so dramatic in medicine. Few if any remedies have done so much in a short time.

The compounds are being used in arthritis, gout, rheumatic fever, myasthenia gravis, depressive states, nephritis, psoriasis, pemphigus, lupus erythematosis, periarteritis nodosa, and other chronic diseases.

Thus far, the results in general have been good. Time will tell, however, as all new products must be digested clinically before the final analysis. At any rate, we hope for the best.—Illinois Medical Journal.

PSYCHIC PROBLEMS FOLLOWING PREGNANCY

Much more attention should be paid by physicians to the psychic problems which develop from economic stress and bad nutritional states the year following a pregnancy. This is fully as important as the prenatal care in terms of the mother's happiness and the emotional security of the child.—Jonathan Forman, M. D., in Ohio State Medical Journal.

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ELEVEN SOCIETIES OVER THE TOP

As this issue of the Journal goes to press, the following component societies have reported a 100 per cent payment of dues by members: Brooke, Doddridge, Eastern Panhandle, Mason, Mercer, Parkersburg, Potomac Valley, Preston, Summers, Taylor, and Wetzel.

At least five other component societies are near the top and probably will be in a position to report a 100 per cent paid up membership by the first of May.

DR. T. G. KLUMPP HONORED

Dr. Theodore G. Klumpp, president of Winthrop-Stearns, and author of several articles concerned with old age problems, has been named by Mayor William O'Dwyer, of New York City, as a member of the Mayor's Advisory Committee for the Aged.

Doctor Klumpp is well known to West Virginia doctors, having appeared on scientific programs of some of the component societies of the West Virginia State Medical Association.

ACCP IN SAN FRANCISCO

The 16th annual meeting of the American College of Chest Physicians will be held at the St. Francis Hotel, in San Francisco, June 22-25, 1950. An interesting scientific program has been arranged for the meeting.

The next oral and written examination for Fellowships will be held in San Francisco June 22, 1950. Candidates for Fellowship in the College should contact Dr. Murray Kornfeld, Executive Secretary, 500 North Dearborn Street, Chicago 10, Illinois.

Dr. George R. Maxwell, of Morgantown, is Governor of the College for West Virginia.

THE DOCTOR'S RESPONSIBILITY

Doctors have tremendous obligations as citizens. They need to take part in helping a sick society to recover and to aid in the creation of a more stable society. Physicians are as capable of knowing human needs and of understanding human relations as any group in our society. It behooves our medical men to be good citizens as well as good doctors. Interest in public affairs today is a major responsibility of the medical profession since there is so much at stake.

In your home communities, each of you is a symbol of free American medicine. As a doctor-citizen you have it especially within your power right now to play a major part in saving our American Way of Life. —Robt. E. Robins, M. D., in New York Medicine.

PHYSICIAN-PHARMACIST RELATIONSHIPS

The obligations of both medicine and pharmacy are reciprocal. Neither profession can properly function without the other. Let the mutual esteem and sincere cooperation that has existed for so many years be maintained and strengthened for the welfare of the United States.—Curt P. Wimmer in New York Medicine.

CHESTNUT LODGE ROCKVILLE, MARYLAND

In addition to its current psychotherapeutic program, Chestnut Lodge now offers facilities for the care, study, and treatment of the elderly patient requiring psychiatric supervision.

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Editor
WALTER E. VEST, M. D.
955 Fourth Ave.
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Managing Editor and
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MR. CHARLES LIVELY
Box 1031
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Vol. XLVI JUNE, 1950 No. 6

DIAGNOSIS IN CONGENITAL HEART DISEASE*

By WM. C. STEWART, M. D.
Charleston, West Virginia

Congenital heart disease, long a neglected medical field, has come of age during the past ten years, and has witnessed outstanding developments. Lack of interest in congenital cardiovascular problems was due primarily to the absence of any satisfactory therapy for these conditions and, appropriately enough, the present enthusiasm among cardiologists is due almost entirely to the remarkable success of several surgical procedures developed in recent years. These operations have been brilliantly conceived and skillfully accomplished. In many instances cures have resulted while in others invalidism has been relieved. Surgical success has been due in part to improved diagnosis which in turn has been due primarily to two new diagnostic procedures. Demonstration of the right ventricle, pulmonary artery and aorta by opaque media, with subsequent angiography, was introduced by Robb and Steinberg[1] and has since received a great deal of study by them and by other observers. Especially helpful insight into the deformities of the pulmonary artery and aorta has resulted from these studies. The most precise and conclusive evidence concerning congenital cardiac lesions has resulted from catheterization of the right heart and pulmonary artery as described by Cournand and Ranges.[2] The study of the oxygen content of blood withdrawn from the right auricle, right ventricle and pulmonary artery, and the exact determination of the pressure in these chambers and vessels has been epoch-making.

These methods of examination, however, have remained in the hands of a relatively few highly skilled investigators. Some danger is associated with their use, and complete familiarity with the procedure is essential if the results obtained are to be reliable and helpful. The large majority of congenital cardiac problems must continue to be studied by the methods regularly at hand, that is, a carefully taken history, physical examination, fluoroscopy, electrocardiogram and such other laboratory procedures as may seem necessary in the individual case. Difficult cases or selected problems may be referred for catheter studies or angiography.

This report deals with the clinical problems involved in the study of 84 cases of congenital cardiovascular disease (table 1). Autopsy has been performed on 3 patients of the 6 who have died, and operation has been performed on 8 patients. In these cases the diagnosis was established. The diagnosis in some cases may be open to question, and perhaps the most instructive cases in this series are those of the 8 patients who seem definitely to have a congenital cardiac condition although it has not been possible in these cases to arrive at a satisfactory anatomic diagnosis.

The cases in this entire series represent patients whose congenital defects were compatible with months or years of life. The large group of extreme malformations which permit only a few hours or a few days of life are not included in a clinical study of this type. Also, it has not been possible to recognize combined cardiac congenital defects clinically except where present in an

*Presented in part before the First Annual Scientific Assembly of the West Virginia Academy of General Practice, at Charleston, October 9, 1949.

established syndrome such as the tetralogy of Fallot.

VENTRICULAR SEPTAL DEFECT

Of the 84 cases studied, the diagnosis of ventricular septal defect was made in 37 (table 2), which constitutes 44 per cent of the series. The presence of a ventricular septal defect often is suggested soon after birth by a harsh systolic murmur at the base of the heart to the left of the sternum. The murmur of ventricular septal defect has been described as being transmitted over the precordium in concentric waves, with the center located at the second or third interspace to the left of the sternum. In the cases comprising this study, transmission of the murmur appeared to be predominantly downward along the left border of the sternum. There is commonly a palpable thrill at the site of maximum intensity of the murmur of ventricular septal defect, and a thrill was noted in 21 of the 37 cases just referred to. The presence of a thrill will depend upon the roughness of the murmur with which it is associated; thus if a rough murmur has been noted, the identification of a thrill may add little evidence toward the diagnosis. However, the finding of a thrill may be said almost invariably to identify an organic lesion and, to this extent, removes all doubt as to whether or not the associated murmur might be functional. An appreciable number of patients with ventricular septal defect will show murmurs of lesser intensity and no thrill. In the classical series of autopsied cases studied by Abbott,[3] there were 50 cases with uncomplicated ventricular septal defect, of which number 38 had a systolic murmur, 19 of these having no associated thrill. In the present study, 16 patients were considered to have a ventricular septal defect who had a systolic murmur at the pulmonic area without an accompanying thrill. The patients in this particular group deserve special consideration.

Table 1

Incidence of Various Types of Congenital Heart Disease

Ventricular septal defect	37
Patent ductus arteriosus	19
Auricular septal defect	9
Tetralogy of Fallot	8
Aortic stenosis	2
Coarctation of aorta	1
Unclassified	8
Total	84

The commonest functional cardiac murmur is systolic in time and heard at the pulmonic area with the patient recumbent. This murmur rarely has any rough quality, and usually is less pronounced with the patient erect. Since this common functional murmur occurs in the same locality as does the murmur of ventricular septal defect, the possibility of confusion is apparent. If one considers the added difficulty of examining a squirming, noisy infant, it raises the important question as to when a diagnosis of ventricular septal defect is justified in the presence of a systolic murmur at the pulmonic area unassociated with a thrill. Sixteen patients showed systolic murmurs of slight to moderate intensity, with definite roughness, but not associated with a thrill. The murmurs were equally as pronounced in the erect as in the recumbent position, and were observed on more than one occasion. It is possible that some of these patients were incorrectly considered to have a ventricular septal defect.

Comparison of the 16 patients who had systolic murmurs without a thrill with the 21 patients whose murmurs were associated with thrills reveals that 5 of the former group showed x-ray evidence of enlargement, and 8 of the latter group showed evidence of enlargement by x-ray or fluoroscopy. Cardiac failure developed in 3 patients who had thrills whereas cardiac failure developed in none of the patients without thrills. Two patients having ventricular septal defect have died. Autopsy was performed in one case, a three month old infant who died of intestinal hemorrhage. This child had a systolic murmur of slight intensity and definite roughness but without a thrill, at the pulmonic area. A ventricular septal defect of 5 mm. diameter was demonstrated at post mortem examination. In summary it may be said that as this study progressed, it became apparent that a diagnosis of ventricular septal defect often is justified when a thrill is absent, but that the diagnosis should be made cautiously.

Table 2

Ventricular Septal Defect Findings in 37 Cases

	Thrill present	*Thrill absent*
	21	16
Rough murmur	21	16
Cardiac enlargement	8	5
Cardiac failure	3	0

X-ray and fluoroscopic examination is a valuable method of diagnosis in congenital heart disease, but in ventricular septal defect this method of examination has its limitations. Fluoroscopy is most helpful in congenital cardiac disorders producing selective enlargement of particular chambers of the heart, or of the pulmon-

ary artery, or of the aorta. The heart may be enlarged in ventricular septal defect, but the enlargement is not remarkable.

Thirteen patients showed cardiac enlargement, but in most instances the enlargement was not more than slight to moderate. When enlargement was present, the right ventricle was most frequently involved, producing a globular heart with symmetrical contour. In a few patients, the left ventricle appeared selectively overactive and slightly enlarged for some obscure reason. Another perplexing observation was that the pulmonary artery was fairly prominent in 7 cases. This finding immediately suggests the possibility that a high ventricular septal defect might be present, and the differential diagnosis of this condition will be considered later in this paper. The electrocardiogram is not remarkable in ventricular septal defect and was not unusual in these cases except that case 24 showed right axis deviation from causes not apparent.

The clinical course of the patient with ventricular septal defect is not marked by evidence of cardiac insufficiency. In infancy, growth and development are not retarded and in childhood, exercise tolerance usually is unimpaired. It rarely is necessary to restrict activity except when it involves very strenuous or competitive effort. Probably the most important reason for recognizing ventricular septal defect is to be aware of its predominantly benign course through childhood and so to avoid the tragedy of a young life unnecessarily limited by restrictions. Cardiac enlargement and congestive failure constitute the common end in this type of heart disease, congestive failure developing in 3 cases at age 37, 52 and 6½ years respectively. Subacute bacterial endocarditis develops occasionally, which happened in the case of an 8 year old patient who responded well to penicillin. Evidence as to how well ventricular septal defect is tolerated is seen in case 30, that of a woman who has had two uneventful pregnancies and who continues well at the age of 56, and in case 25, that of another woman who has had five pregnancies and who continues well at the age of 45. Both of these patients have rough murmurs and thrills, and the diagnosis probably is certain, yet at the time of the last examination both had hearts which were full but not definitely enlarged.

The differential diagnosis in ventricular septal defect usually offers no great difficulty. Isolated pulmonic stenosis is characterized by a rough systolic murmur and thrill at the pulmonic area, and might present a diagnostic problem. However, this lesion usually is accompanied by enlargement of the right ventricle, with right axis deviation shown in the electrocardiogram. Furthermore, isolated pulmonic stenosis is very rare and ante mortem diagnosis has been made infrequently. Patent ductus arteriosus presents some features resembling the findings in ventricular septal defect, but the machinery murmur of the former is classical, likewise the enlargement of the pulmonary artery and its branches is seen rarely in ventricular septal defect. In auricular septal defect, a systolic murmur similar in some respects to that found in ventricular septal defect may be present, but the unique cardiac and pulmonary artery enlargement found in auricular septal defect is distinctive. The most difficult diagnosis will be between ventricular septal defect and the common functional murmur heard at the pulmonic area.

PATENT DUCTUS ARTERIOSUS

Patency of the ductus arteriosus is the next most frequent congenital defect of the heart and great vessels, and the diagnosis can be made with accuracy by ordinary clinical methods of examination. Identification of these cases is extremely important in view of the dramatic results of surgical treatment. Nineteen patients in this series were found to have a patent ductus arteriosus. This high incidence probably is due to the more determined search for these cases plus the fact that error and confusion in the diagnosis of patent ductus arteriosus should rarely occur.

These patients have had very few cardiac complaints. Growth has been retarded in a few, but this has been the exception rather than the rule. The presenting complaint, if any, has been awareness of the heart and undue palpitation on exertion. Congestive failure has developed in only one patient, and most have not complained of troublesome shortness of breath. Subacute bacterial endocarditis developed in one patient but he responded to penicillin therapy, and the ductus was then successfully ligated. Four female patients have gone through pregnancy without any difficulty. While most of these patients were aware that they had some tye of heart abnormality, only the patient with subacute bacterial endarteritis and the one with congestive failure presented any urgent symptoms.

Table 3 summarizes the significant findings in patient ductus arteriosus. A machinery murmur at the pulmonic area is the pathognomonic finding and is unmistakable. The rough systolic phase and the softer diastolic component form a continuous murmur. In infancy, the systolic and diastolic murmurs may have the same quality, and occasionally the diastolic murmur may be absent. As the child grows older, the aortic pressure be-

comes significantly greater than that in the pulmonary artery, and the classical murmurs develop. In these cases, no diagnosis of patent ductus arteriosus was made in the presence of a systolic murmur alone. A thrill was felt at the site of maximum intensity of the systolic murmur in 12 of the 19 cases. The thrill was sharply localized while the systolic murmur always could be heard in the left posterior chest and usually was transmitted also to the apical region of the heart. In patent ductus arteriosus, lowering of the diastolic pressure, producing a wide pulse pressure, is a frequent finding and in its incidence is second only to the machinery murmur. Thirteen cases in this series showed a lowered diastolic pressure. Hubbard[4] considers that the degree of lowering of the diastolic pressure is a good index of the extent to which the patent ductus is imposing a mechanical burden on the heart. Cardiac enlargement was found in 12 cases but was usually of only slight to moderate degree. X-ray and fluoroscopic examinations frequently are helpful and, in this study, revealed prominence of the pulmonary artery in 12 cases and hilar dance in 5. The left ventricle often was found to be overactive, but the cardiac enlargement usually was symmetrical and not remarkable. The electrocardiogram has been normal when done in these cases, thus has not been helpful. Right axis deviation, when present, would suggest some type of complicating lesion.

Table 3

Patent Ductus Arteriosus Findings in 19 Cases

Machinery murmur	19
Wide pulse pressure	13
Cardiac enlargement	12
Thrill	12
Prominent pulmonary artery	12
Hilar dance	5

Six of the patients with patent ductus arteriosus have been successfully operated upon. The results have been excellent in five cases. One patient has a persistent rough systolic murmur in the region of the ligated ductus which cannot be explained. One patient who had a patent ductus ligated was found to have, in addition, an auricular septal defect, and has not done well.

Two patients of the 19 with patient ductus arteriosus are past 30 years of age with no appreciable cardiac enlargement, and are well compensated. They have not been urged to undergo surgery. Five patients have passed the age of 20, and are so well that they have not been receptive when advised to submit to surgery. One patient (case 58-B) is 52 years old, now has congestive failure, and is being considered for surgery.

All infants and children should be operated upon regardless of the presence of favorable considerations in the individual case. While the operation remains a formidable one, the mortality has been reduced to about 2 per cent by improved technic, and a favorable outcome with dramatic results can be expected.

AURICULAR SEPTAL DEFECT

Auricular septal defect was the third most frequently encountered congenital malformation in this series. This rating represents a greater incidence of the condition than is generally recognized. Several features of these cases make them among the most interesting of all congenital malformations. In infancy, auricular septal defect is almost impossible to recognize. In adolescence and adult life it may be missed but, if suspected, can be identified with certainty in most cases. The largest hearts encountered in patients with congenital cardiac defects develop in these cases. But despite this fact the patients often continue to be compensated for years. Nine cases of auricular septal defect were found in this series.

Auricular septal defect is not to be confused with patency of the foramen ovale. In approximately 10 per cent of normal hearts some degree of patency of the foramen ovale is present but has no disturbing effect on the cardiac function. On the other hand, in auricular septal defect, the defect in the midseptum usually is 2 to 3 cm. in diameter, and profoundly influences the blood flow through the heart and, secondarily, through the lungs. Arterial blood returning from the lungs enters the left auricle but, instead of passing through the mitral valve into the left ventricle in normal fashion, a large amount of the output of the left auricle passes through the septal defect into the right auricle. There has been no unanimous agreement as to why the flow of blood through the septal defect is from left to right. Uhley[5] has attributed the direction of flow to the dependent position of the right auricle as compared with the left, the flow from left to right being the result of the law of gravity. Hull[6] recently has suggested that blood flowing through the right auricle and thence through the tricuspid valve and into the right ventricle meets less resistance than when flowing through the mitral valve and into the left ventricle. All investigators agree that large quantities of oxygenated blood pass from left to right through the septal defect and that this increases right ventricular filling to a considerable extent. Consequently, due to the

great increase in blood flow through the right side of the heart, the right auricle is greatly dilated and the right ventricle dilated and hypertrophied. Blood flow through the pulmonary arteries similarly is increased and these vessels are dilated to an extreme degree, greater than is seen in any other form of heart disease. Dilatation and enlargement of the right side of the heart and pulmonary artery provide the diagnostic features of auricular septal defect, and appreciation of these changes permits an insight into the physical findings in these patients (table 4).

Infants and young children with auricular septal defect usually are poorly developed and frail. Three of the 4 children in this series are very delicate. The tendency to disproportion between skeletal and muscular development often is remarkable. Of five adults with auricular septal defect, 3 were poorly developed and underweight while 2 patients were of about normal physique. These patients are notoriously susceptible to infections, particularly bronchitis and pneumonia. A nine year old girl (case 71 in this series) has had pneumonia on four occasions and with each infection has raised bloody sputum. One other child has had bronchitis but otherwise the incidence of pulmonary infection has not been outstanding. Irregularities of the heart have been encountered commonly in this type of congenital heart disease, and 3 adult patients have had such complaints. Two adults have suffered frequent bouts of paroxysmal tachycardia. Cyanosis is not to be expected in auricular septal defect, and none of the 9 patients in this group was cyanotic. Females preponderate in the recorded incidence of auricular septal defect, usually about 2 to 1. In these cases there were 7 females and 2 males. It is of some interest that two of these patients were sisters. One died of congestive failure at the age of 35, and the other remains fairly well at the age of 42.

A consistent finding in auricular septal defect is cardiac enlargement, which was present in all of the cases in this group. The contour of the heart is typical, with enlargement through the right auricle and ventricle. The apex of the heart is formed by the enlarged right ventricle and is blunted and lifted up. The cardiac enlargement usually is great, the heart at times being of immense size. Case 69, previously referred to, has been observed for thirteen years. This patient's heart appeared almost completely to fill the chest at the outset, with little change in its size having been noted. Enlargement of the right ventricle anteriorly is common, and deformity of the chest wall may result. One patient in this group showed marked bulging of the anterior chest wall while one showed a slight deformity. Enlargement of the pulmonary artery and its branches, as demonstrated by x-ray and fluoroscopy, is the most characteristic feature of auricular septal defect. The enlargement is striking. All patients in this group showed enlargement of the pulmonary artery, and in 3 cases, pulsation, which has been called 'hilar dance' was seen on fluoroscopy. A hypoplastic aorta has been found in many cases, with the aortic knob small as shown by the fluoroscope. This last was not an impressive finding in these cases. Right axis deviation, revealed by the electrocardiogram, is a logical feature in the presence of right ventricular enlargement such as occurs in auricular septal defect. Electrocardiograms,

Table 4

Auricular Septal Defect Findings in 9 Cases

Cardiac enlargement	9
Enlarged pulmonary artery	9
Right axis deviation	7
Rough systolic murmur at pulmonic area	6
P_2 increased	6
Hilar dance	4
Paroxysmal arrhythmia	3
Diastolic murmur	3
Slight systolic murmur	3
Systolic thrill	1

available in 7 patients in this group, all showed right axis deviation. Auscultation of the heart often is not impressive and rarely contributes to the diagnosis. In this group, 6 patients showed a rough systolic murmur at the pulmonic area, and 3 showed slight systolic murmurs. In two instances, rough systolic murmurs were associated with thrills. Three patients showed diastolic murmurs along the left border of the sternum. Increase in the pulmonary second sound was noted in 6 cases.

Stenosis of the mitral valve has been observed frequently in association with auricular septal defect, and the combination has been designated Lutembacher's syndrome. Case 70 in this series is thought probably to represent this condition.

Two patients with auricular septal defect have died of congestive failure at the ages of 35 and 53 respectively. In both instances the period of congestive failure was prolonged. The rest of the adults in the group have remained compensated despite great cardiac enlargement. Although these patients are characteristically frail and may have limited cardiac reserve, they show an amazing capacity to carry on fairly active lives. The three surviving adults are aged 42, 44 and 45 years respectively, and appear to be maintaining their cardiac reserve.

TETRALOGY OF FALLOT

When any child shows persistent cyanosis, the most likely diagnosis is the tetralogy of Fallot. Although certain other malformations of the heart result in cyanosis, they permit of only a few days of life. On rare occasions, other congenital defects are associated with cyanosis in the terminal stages, and particularly so when heart failure develops. In this series of cases, 8 patients were considered to have the tetralogy of Fallot and all were cyanotic. The diagnosis in one case was confirmed at autopsy, and in two other cases when the patients underwent a Blalock-Taussig[7] operation.

The patients in this group have been retarded physically and, in some instances, mentally. Their exercise tolerance usually has been extremely limited on account of shortness of breath. Weakness and lack of vigor have been notable. There has been a high incidence of acute infections, particularly of the respiratory passages.

Table 5

Tetralogy of Fallot Findings in 8 Cases

Cyanosis	8
Polycythemia	8
Clubbing	4
Rough systolic murmur at pulmonic area	4
Slight systolic murmur	4
Right axis deviation	4
Cardiac enlargement	4
Systolic thrill	3

Cyanosis almost invariably is associated with an increase in the red blood cells and in hemoglobin, which was true in all of these cases (table 5). Clubbing of the fingers and toes which traditionally is associated with cyanosis and polycythemia, was present in only 4 cases. A rough systolic murmur at the pulmonic area was found in 4 cases, and a systolic murmur of only slight intensity and roughness was present in the remaining 4 cases. A systolic thrill was present in only 3 cases which is a lower incidence of this physical finding than usually is found. The electrocardiogram is helpful in the tetralogy of Fallot, as right axis deviation is the rule. Electrocardiograms were made in five of the eight cases, and all five showed right axis deviation. X-ray examination is extremely important in this condition. Only two patients in this group showed cardiac enlargement, which is in agreement with the findings of other observers. Demonstrable cardiac enlargement is not usually observed but when present involves the right ventricle and produces enlargement anteriorly against the chest wall. In addition, the apex of the heart is lifted up and blunted. Since the pulmonary artery is small, the waist of the heart is thin, with a concavity along the left border, and the hilus and shadows are diminished. This observation, however, was not particularly impressive in our cases.

The two patients who underwent a Blalock-Taussig operation were distinctly benefited. Cyanosis was lessened, and exercise tolerance improved. As yet there have been no undesirable sequelae to the operations.

AORTIC STENOSIS

Aortic stenosis is an uncommon congenital defect. The stenosis may be produced either by malformation of the aortic valves or the subaortic region. The aortic cusps may be thickened and deformed, producing marked stenosis, but in some instances the deformity of the valve produces very little narrowing of the valve orifice. Subaortic stenosis usually is produced by the persistence of web-like bands across the aorta immediately beneath the aortic valves. These bands may be fused at times to form an almost complete diaphragm. The degree of obstruction, whether due to aortic or subaortic stenosis, varies greatly, and the degree of stenosis usually is reflected in the roughness of the murmur and thrill and in the alteration of the blood pressure and pulse. Tortuosity of the aorta is a condition commonly associated with aortic stenosis. Aortic stenosis was present in two cases in this study and, because this condition is so rarely encountered, these cases will be reported in some detail.

Case 73.—J. A. U., an 11 year old girl, was first seen at the age of 4, having been referred by her family physician who had recently noted a heart murmur. She had always been well and had never had rheumatic fever nor chorea. She was vigorous, active and well developed. Since she was first seen, she has been examined yearly by the writer. She continues well, has missed very little school, and complains of no fatigue nor dyspnea. She has never been cyanotic. She has persistently shown a grade 5 systolic murmur at the aortic area transmitted into the neck and over the precordium, particularly to the apex where it is grade 3 intensity. A rough thrill is associated with the murmur. The aortic second sound is faintly heard. It had never been possible to record a blood pressure in the case of this child until within the past three years when a few beats have come through at 90 mm. of mercury on the sphygmomanometer. The pulse has been barely perceptible at all times. An electrocardiogram shows left axis deviation; fluoroscopic examination on numerous occasions has shown a heart

approximately normal in size but with a sharply outlined overactive left ventricle. The aorta is tortuous and slightly widened.

Case 74.—J. K., an 11 year old girl, was first seen at the age of 9 when she was referred by her family physician because a heart murmur had been noted. A heart murmur was first reported at age 2. She had never been cyanotic and had no cardiac complaints. She had developed well and had attended school regularly without difficulty. There was no history of rheumatic infection nor chorea.

Physical examination showed a thin but normally developed child. A grade 5 systolic murmur was heard at the aortic area, associated with a rough thrill. The murmur was transmitted into the neck and widely over the precordium, particularly to the apex where it was grade 3 in intensity. The sounds at the base of the heart were approximately normal. The blood pressure was 114 systolic and 84 diastolic, and the pulse was not unusual. An electrocardiogram was not available in this case; fluoroscopy showed the heart to be slightly enlarged through the left ventricle. The aorta was tortuous and overactive.

In these two cases, the diagnosis of aortic stenosis probably cannot be questioned. It is not possible to make a rational guess as to whether the stenosis is aortic or subaortic in a given case. Both patients have tolerated the lesion unusually well, and this is true to an amazing extent in case 73. This patient has continued well despite an almost imperceptible pulse and blood pressure for years.

A rough systolic murmur with a thrill at the aortic area, some enlargement of the left ventricle with an overactive aorta, left axis deviation as shown by electrocardiogram and narrow pulse pressure with a small peripheral pulse may be expected in most cases of aortic stenosis. The transmission of the aortic systolic murmur to the apex of the heart usually is remarkable, and suggests the presence of mitral insufficiency. Subacute bacterial endocarditis is an ever present danger in these cases.

COARCTATION OF THE AORTA

Coarctation of the aorta is an uncommon condition, and although it may be associated with malformations of the heart, such is not usually the case. The narrowing of the aorta may be diffuse as in the infantile type, or it may be rather sharply localized as in the adult type (the infantile type being so-called because, as a rule, it is incompatible with more than a few weeks of life). The narrowing of the aorta in both instances usually occurs between the origin of the left subclavian artery and the point of origin of the ductus arteriosus. Coarctation of the aorta characteristically produces hypertension in the upper extremities, and absent or very weak pulsations in the abdominal aorta, and the femoral and other arteries of the lower extremities. Identification of this discrepancy provides the key to the diagnosis, and supporting evidence in the form of enlarged anastomotic arteries about the shoulder girdle and upper chest is helpful. Erosion of the lower margins of the ribs in the midthoracic region by dilated intercostal arteries can be demonstrated by x-ray, and is pathognomonic of coarctation of the aorta. This condition, however, usually does not develop until the twelfth to fourteenth year of life and, for this reason, the diagnosis in children may be difficult. Furthermore, coarctation of the aorta does not alter the blood pressure in any consistent fashion. The pressure in the brachial artery may be normal in the presence of considerable narrowing of the aorta, and the pressure in the lower extremities also may be normal. Of the four cases studied by Taussig,[8] none had an elevated systolic blood pressure. The physical findings are subject not only to great variation but symptoms often are absent or minimal. Serious manifestations may not appear until after many years of active life.

One case of coarctation of the aorta has been observed for a period of eight years. A 22 year old engineer was first seen in 1941. A diagnosis of coarctation of the aorta had been made elsewhere in 1934. The patient had no complaints, but mild hypertension had been noted since the age of 15. The blood pressure in the right arm was 160/80 mm. Hg. and notably less than in the left arm, being 130/84 mm. Hg. The pulsations of the aorta and femoral arteries were weak, and the pressure was 100/80 mm. Hg. at the thigh. X-ray of the chest showed the heart to be normal in size, with the left ventricle slightly prominent and the region of the aortic arch less prominent than would be normally expected. There was no erosion of the inferior margins of the ribs. Fairly prominent pulsations were noted along the medial borders of the scapulas, a grade 2 systolic murmur was heard at the pulmonic area, and a faint but distinct systolic murmur was heard over the 4th thoracic vertebra.

Despite the fact that no erosion of the ribs has been demonstrated in this case, the diagnosis of coarctation of the aorta appears definite. As a boy, this patient was an enthusiastic mountain climber and tennis player. Although his activity has been restricted for several years, he continues well. There is one notable feature in this case: the fact that the patient's diastolic pressure in

the upper and lower extremities was about the same, a finding noted in some cases by other observers. The moderate elevation of the blood pressure in the right arm and the absence of evidence of extensive collateral arteries suggest a mild coarctation which is borne out by the absence of any symptoms. An operation for removal of the aortic constriction, and direct anastomosis of the resected aorta has been developed by Gross[9] and by Crafoord.[10] In the case of this patient as well as in other cases in which there is little evidence of embarrassment due to aortic deformity, an operation should not be attempted in view of its formidable nature. Moreover, patients beyond the age of 20, because of the likelihood of sclerotic changes in the aorta, are not suitable candidates for surgical treatment.

DEXTROCARDIA

Dextrocardia was encountered in two cases in this series and appeared to be complicated by other cardiovascular malformations in both instances. These cases are presented in detail with the group of cases in which it was not possible to arrive at a satisfactory anatomic diagnosis. Experience in these two cases emphasizes the point that while dextrocardia in itself is harmless enough, it is not infrequently associated with other, at times, serious deformities of the heart and great vessels.

CASES WITHOUT FINAL DIAGNOSIS

The study of any sizable group of patients with congenital heart disease, using the commonly available clinical methods, will reveal a certain number of cases in which it is impossible to arrive at a satisfactory anatomic diagnosis. Until recent years, this fact caused no particular concern. Indeed, the problem of diagnosis was considered settled when a decision as to the presence of congenital heart disease had been reached. Today, the choosing of cases for surgical treatment necessitates greater care in the study of these cases and, gradually, the number in which final diagnosis cannot be made has been greatly reduced. The size of the group will vary in proportion to the experience, skill and persistence of the examiner. The anatomic diagnosis in these cases usually can be made by angiocardiography and right heart catheterization. Any undiagnosed case of congenital heart disease which it is believed might be benefited from surgical treatment should have the advantage of these studies. Eight patients in this series are without final diagnosis, and consideration of the problems presented in the study of these cases should be instructive. Consequently, they are presented in detail.

Case 1.—A. L. B., a 15 year old boy, was first seen Feb. 27, 1946 complaining of 'choking spells' associated with nausea and cold sweating. He tired easily and had never been capable of normal activity. He complained also of palpitation. His past history revealed that he had had repair of bilateral inguinal herniae at 3 months of age. He had had occasional convulsions until he was 7 years of age. He had never had rheumatic fever nor chorea. He was known to have dextrocardia; a heart murmur had been noted since birth.

Physical examination showed a poorly developed white boy weighing only 93 pounds. The skin was normal in color. The right chest anteriorly was prominent and bulging. The apical impulse was at the nipple line on the right. The rhythm was regular and the heart sounds intense. A grade 2 systolic murmur was heard at the base of the heart to the right of the sternum. The blood pressure was 112 systolic and 52 diastolic. Fluoroscopy showed the heart to be of normal size and located in the right chest. The apex was blunted and lifted, and the retrosternal space was diminished. The aortic arch was on the left, and the pulmonary artery was not abnormal. Electrocardiogram showed a mirror-image lead I; lead II looked like the usual lead III, and lead III resembled the usual lead II. X-ray with barium showed the stomach and bowel to be in normal position, and additional x-rays showed several anomalies of the ribs and spine.

This patient has dextrocardia with left aortic arch without *situs inversus*. Uncomplicated dextrocardia should not produce cardiac symptoms, and the extent of this patient's physical retardation plus his cardiac symptoms suggests that he has some complicating lesion. Taussig[8] states that dextrocardia in the presence of left aortic arch and without *situs inversus* is likely to be associated with other serious cardiac malformations. Examination of the heart plus fluoroscopy in the case of this patient provides no clue to the nature of additional deformities. There was some evidence of enlargement of the right ventricle, but this did not point to any definite lesion. It was felt that this boy had dextrocardia with some additional cardiovascular malformations, but no final diagnosis was made.

Case 2.—P. C., a 26 month old female child, was first examined July 9, 1948. The patient had had a normal course following birth and had not been cyanotic. Dextrocardia had been discovered on routine examination. The mother of the child had had a patent ductus arteriosus ligated successfully 6 months after her delivery.

Physical examination showed the child to be pale and poorly developed. The heart was in the right chest. A rough, grade 4 systolic murmur was heard in the 2nd and 3rd interspaces to the right of the sternum. The murmur was transmitted upward toward the right clavicle and to the apex where it was grade 3. No thrill was noted. The second sound at the base of the heart to the right of the sternum was greatly increased. Fluoroscopy showed the heart to be in the right chest and moderately enlarged. No definite chamber enlargement could be identified although the apex was blunted as in right ventricular hypertrophy. The aortic arch was on the right and the pulmonary artery was normal. Electrocardiogram showed the typical findings of dextrocardia, with normal conduction times. The liver was on the left, and it was thought that complete *situs inversus* was present.

Dextrocardia, with right aortic arch, is not as frequently associated with additional malformations of the heart as it is when left aortic arch

is present. However, the rough systolic murmur and cardiac enlargement definitely establish the presence of an additional deformity in this case. The possibility of aortic stenosis was suggested by the transmission of the murmur upwards and, at the same time, to the apex of the heart. The fact that no thrill was present and that the murmur was to the right of the sternum opposed the diagnosis of aortic stenosis. Ventricular septal defect seemed the most likely diagnosis, but the extent of the cardiac enlargement and the poor development of the child were against it. No satisfactory final diagnosis could be made.

Case 3.—M. E., a nurse, was first examined Oct. 5, 1945, at the age of 26, and subsequently has been examined often. A heart murmur was first noted in infancy. She had been kept out of school a large part of the time, and her activity had been restricted. She had shown persistent hypochromic anemia. She had had no difficulty during her nurse's training, and had been capable of full activity in recent years although bothered with slight dyspnea.

Physical examination showed a somewhat pale, well developed young woman. There was no cyanosis. The heart showed regular rhythm, rate 72. A grade 3 systolic murmur was heard at the pulmonic area. The murmur was very sharply localized and not transmitted, but could be heard in the back. A definite faint thrill was noted on several occasions. The blood pressure was 112 systolic and 74 diastolic. The P_2 was sharply increased. Fluoroscopy showed the heart to be moderately enlarged. The enlargement was along the right border of the heart, but the left ventricle also was overactive and slightly prominent. The pulmonic conus was greatly enlarged. No hilar dance was present. No auricular enlargement could be identified. An electrocardiogram was normal.

The striking enlargement of the pulmonic conus and pulmonary artery was the outstanding finding in this case. The cardiac enlargement indicated that the lesion of the heart or great vessels in question was imposing some strain on the heart, but the absence of any axis deviation suggested that such strain was not selective upon either ventricle. The fluoroscopic examination indicated some enlargement of both chambers also. Patent ductus arteriosus was considered as a likely diagnosis in this case, except that no diastolic murmur was present to complete the continuous murmur typical of this condition. The consensus at this time favors the diagnosis of patent ductus arteriosus only in the presence of a continuous murmur, although Keys and Shapiro[11] reported a case, proven by autopsy, in which no murmur was heard before death. Also, Chapman[12] and others, in cases studied by right heart catheterization, noted a systolic murmur but no diastolic murmur in 4 out of 22 cases of patent ductus arteriosus.

Another diagnosis entertained in this case was congenital dilatation of the pulmonary artery. Greene[13] and others have reported 8 cases with this diagnosis, after right heart catheterization and careful clinical evaluation. Their cases were similar in many respects to that of our patient, and congenital dilatation of the pulmonary artery is a distinct possibility in this case. However, it has not been possible to make a final diagnosis.

Case 4.—D. E., a 4½ year old girl, was first examined May 21, 1947. She had been born prematurely, and during the first year of life showed some cyanosis on crying. She had grown well but tired easily at play. A murmur had been noted since birth.

Physical examination showed no cyanosis and no clubbing. A very rough, grade 5 systolic murmur was heard at the pulmonic area with transmission chiefly upward under the left clavicle. The murmur was transmitted downward also, and to the apex of the heart to a less marked degree. It could be heard in the back. There was a thrill at the pulmonic area. The A_2 was greater than the P_2 which seemed definitely diminished. Fluoroscopic examination showed the heart to be normal in size. The pulmonary conus and artery were moderately dilated. An electrocardiogram showed well marked right axis deviation.

The rough systolic murmur and thrill at the pulmonic area suggest ventricular septal defect or a lesion of the pulmonary valve or artery. The predominant transmission of the murmur upward favors pulmonary stenosis as does the existence of the right axis deviation. However, pulmonary stenosis is an uncommon condition, and diagnosis during life, using the commonly available clinical methods, rarely is possible. Another possibility in this case is ventricular septal defect. Taussig[8] divides ventricular septal defect into the classical Roger's disease and high septal defect in which the aortic septum fails to meet the ventricular septum. In these cases there is dilatation of the pulmonary artery in addition to the usual signs of ventricular septal defect. Because of the conflicting evidence in this case, no satisfactory anatomic diagnosis could be made.

Case 5.—L. P., a 6½ year old boy, was first examined October 4, 1947. A murmur had been noted since the patient was one year of age. He was sickly and had never gained weight satisfactorily. He had never been cyanotic, but tired quickly and did not tolerate exercise well.

Physical examination showed a pale, thin boy with a grade 4 to 5 systolic murmur at the pulmonic area. The murmur was transmitted less strongly to the aortic area. There was no transmission of the murmur downward nor was it heard at the apex. No thrill was present. The P_2 was plus 3. The blood pressure was 86 systolic and 64 diastolic. Fluoroscopy showed the heart to be of normal size and contour; the pulmonary artery and the aorta were not remarkable.

The rough systolic murmur was the only significant observation in this case, and it probably is questionable as to whether this constitutes sufficient evidence on which to base a diagnosis of organic disease. Selzer,[14] in a study of autopsy material and clinical records, has demonstrated that rough systolic murmurs at the base of the heart often may be found in cases in which no abnormality of the heart and great vessels is found at autopsy. However, it seems to us that a

grade 4 to 5 systolic murmur, when encountered in practice, must be considered strong evidence of organic disease even though (as in the present case) other significant observations are not present. The important feature in this case was the strict limitation of the rough systolic murmur to the base of the heart, with striking transmission into the left shoulder and back. This condition suggested an abnormality of the great vessels, but no satisfactory diagnosis could be made.

Case 6.—M. J. J., a six week old female infant, was first examined Nov. 9, 1947, and subsequently has been examined several times. The child has had noisy labored breathing since birth, but has never been cyanotic. She always has been restless, and up to age 2 had not gained weight satisfactorily. Some grunting respiration had been noted with the patient at rest.

Physical examination showed no cyanosis. The left chest was bulging and prominent. The heart was overactive and greatly enlarged. A grade 3 to 4 systolic murmur could be heard along the left border of the sternum. No thrill was present. The heart sounds were not altered at the base, and the apical first sound was muffled. Blood pressure was 76 systolic and 40 diastolic. Fluoroscopy showed the heart to be greatly enlarged to the right and to the left. The apex was blunted and lifted up producing a "wooden shoe" contour. The pulmonary artery was somewhat prominent but not greatly so. Enlargement of the right ventricle had filled the retrosternal space and was causing pressure against the anterior chest wall. An electrocardiogram showed great amplitude of all deflections of the string but no axis deviation.

Many of the findings in this case suggested auricular septal defect. Two important objections to this diagnosis lay in the fact that the pulmonary artery did not show dilatation and that the electrocardiogram did not show right axis deviation. Enlargement of the right ventricle as shown by fluoroscopy but absence of right axis deviation as shown by the electrocardiogram provided apparently contradictory evidence which added to the confusion, and no final diagnosis was possible.

Additional Note.—This patient subsequently was examined at Johns Hopkins Hospital and a diagnosis of truncus arteriosus was made. In this condition, the aorta and pulmonary artery are fused and usually there are no branches to the lungs, which are supplied by a collateral circulation.

Case 7.—C. D., a 22 year old white man, was first examined Dec. 28, 1949. A heart murmur had been noted since infancy. He had not had rheumatic fever nor chorea. No cyanosis had been noted at any time, and he had been very active in high school athletics. Dyspnea had been noted on strenuous activity during the past three years.

Physical examination showed a well developed white male. There was a heaving impulse over the left precordium. An occasional premature beat was noted. A grade 4 systolic murmur was heard along the left border of the sternum from the 2nd interspace and extending to the apex of the heart. The P_2 was plus 3, and the apical first sound was increased. No thrill could be felt. The blood pressure was 120 systolic and 60 diastolic. Fluoroscopy showed the heart greatly and fairly symmetrically enlarged, but with blunted apex. The right ventricle was enlarged anteriorly to the chest wall. The hilus shadows and great vessels appeared to be normal. An electrocardiogram showed marked right axis deviation.

The murmur in this case was similar in quality and location to that found in ventricular septal defect, but no thrill was present. The marked enlargement of the right ventricle and the finding of marked right axis deviation are very uncommon in ventricular septal defect. The presence of a normal pulmonary artery by fluoroscopy was very important. These findings strongly favored a lesion of the pulmonary valve such as pulmonary stenosis. The absence of a thrill and the predominant transmission of the murmur downward along the left border of the sternum and to the apex oppose this diagnosis. The diagnosis of pulmonary stenosis rarely is possible during life unless angiocardiography or right heart catheterization has been done. This case has not been finally classified.

Case 8.—S. M., a 6 year old girl, was first examined Oct. 30, 1947, and has been examined frequently since that time. She had never been well since birth. At one year of age, she underwent an operation for pyloric stenosis. She had not learned to walk until late, and had shown marked scoliosis. A heart murmur had been heard since birth. She had extreme myopia which could not be corrected by glasses. Her limbs had been thin always. Her chief complaints were shortness of breath and extreme fatigue. She had never been cyanotic and had not had rheumatic fever nor chorea.

Physical examination showed an extremely frail child with marked scoliosis and bulging of the left anterior chest. There was no dislocation of the lenses of the eyes. The hands showed the classic spider appearance as in arachnodactylia. The heart action was heaving in character and the apical impulse was prominent and diffuse. There was great cardiac enlargement. The rhythm was regular, the rate 90. A grade 4 systolic murmur was present at the apex of the heart, transmitted upward toward the pulmonary area. A short, fairly rough early diastolic murmur was heard at the left border of the sternum. A thrill was present. The apical first sound was sharply increased, and the pulmonary second sound was markedly increased. The blood pressure was 96 systolic and 60 diastolic. Fluoroscopy was very difficult in this case because of the deformity of the chest and spine. The heart was greatly and fairly symmetrically enlarged, with the apex blunted. The right ventricle appeared to be selectively enlarged. There was some enlargement of the pulmonary artery but it was not remarkable. An electrocardiogram showed the P-R interval 0.20 seconds, QRS 0.8 second, but no axis deviation.

The patient in this extremely interesting case has serious heart disease and all of the evidence points toward congenital heart disease. The congenital abnormalities present, the heart included, suggest that this case might very well have been included in that group first described by Marfan[15] in which arachnodactylia is associated with heart disease. The subject was reviewed in detail by Uyeyama[16] and associates who presented additional cases. The case presented here represents congenital heart disease, and auricular septal defect was a possible diagnosis. However, the

enlargement of the pulmonary artery was not striking, and the absence of right axis deviation opposed the diagnosis of auricular septal defect. There are many possible anatomic diagnoses in this case, no final conclusion having been reached.

DISCUSSION

In this study of problems encountered in the diagnosis of congenital heart disease, those malformations of the heart and great vessels which are incompatible with life and result in stillbirth, or death after a few hours or days of life, have not been considered. In addition, it has not been found possible to detect successfully combined congenital defects by means of the usually available clinical methods of examination. As a result, the anatomic diagnoses made in these cases do not represent the true incidence of the various defects encountered at post mortem examination. The diagnosis may be questioned in some of these cases, but where uncertainty exists an effort has been made to be guided by the preponderant clinical evidence.

The presence of congenital heart disease in infants usually is first suggested by the observation of a rough systolic murmur at the base of the heart. In most cases, there is very little about the infant's appearance to suggest the presence of heart disease. Cyanosis was found in only 10 per cent of these cases. In about 30 per cent of the cases, growth and development had been delayed, and the patients were frail. Feeding problems and infections have been frequently encountered. Shortness of breath, being a subjective symptom, has not been helpful in evaluating the problem in infants and children. In children and adults, palpitation has been a very common symptom, and frequently the only one. The palpitation often has taken the form of an excessive awareness of the heart action without particular regard to alteration of rate or rhythm.

Ventricular septal defect was the type of congenital heart disease most frequently encountered. Growth and development were rarely disturbed by this lesion, and the cardiac reserve continued good into adult life. A rough systolic murmur with a thrill at the pulmonic region is the distinctive finding in these cases, and is diagnostic provided fluoroscopic examination shows the heart to be of normal size and contour, with a normal pulmonary artery. In somewhat less than one-half of these cases, the systolic murmur was of only moderate roughness and intensity, and was not accompanied by a thrill. Diagnosis is difficult in some instances. In infants it probably is unwise to make a final diagnosis of ventricular septal defect in the absence of a thrill. Many systolic murmurs noted under these circumstances will prove later to be functional. Limitation of activity in young children suspected of having congenital heart disease is extremely difficult of accomplishment, and in ventricular septal defect usually is unnecessary and unwise.

The incidence of patent ductus arteriosus in this series of cases was surprising. Nineteen patients, or 24 per cent, had this congenital defect. These patients had very few symptoms. Some had suffered a decrease in their cardiac reserve but this was not remarkable; likewise, retarded development was not impressive. In one patient subacute bacterial endarteritis developed, while in another patient, aged 52 years, congestive failure has developed. In addition, one patient who had patent ductus arteriosus and auricular septal defect has not done well despite successful ligation of the ductus. Otherwise, the large majority have had very few complaints. Keys and Shapiro[11] have found the life expectancy of patients with patent ductus arteriosus to be reduced by 25 years on the average, and in their cases found congestive heart failure and subacute bacterial endocarditis to be the chief causes of death. In the present series, these conditions have been encountered but rarely. Six patients have been operated upon successfully, and 13 patients have not been operated upon for one reason or another. Eight of the 13 patients not operated upon are adults whose average age is 31 years. All except one (case 58-B previously mentioned as having congestive failure at age 52) are doing well. Experience with this group of patients does not indicate that it is essential for all such patients to be operated upon, but suggests that selection of cases is advisable and should be possible. The selection of patients can be best accomplished in adults, in whose cases estimation of cardiac reserve is more practical. In view of the fact that surgical treatment produces such a dramatic cure with only very slight risk, it appears to be the treatment of choice in all children, in which class of patients selection of cases offers particular difficulty. The diagnosis of patent ductus arteriosus is not difficult. The machinery murmur with systolic thrill, the lowered diastolic pressure and the enlarged pulmonary artery rarely leave one in doubt as to the nature of the condition in question.

Auricular septal defect presents particular features of considerable interest. In infants and young children suspected of having heart disease but presenting a confused picture, auricular septal defect always should come to mind. The diagnosis is no less a problem in adults except

that electrocardiography and fluoroscopy are more satisfactory and are invariably helpful. Growth has been restricted in most patients with auricular septal defect in this series, and often the effect is striking. One adult and one child have developed satisfactorily, and have normal vigor. Frailty is more often associated with auricular septal defect than with ony other commonly encountered congenital cardiac condition except the tetralogy of Fallot. The cardiac reserve is also limited in most of these patients. Only two patients (cases 66 and 72-A, 10 year old and 7 year old boys respectively) appear to have normal exercise tolerance. Although the cardiac reserve is rarely normal, further loss of reserve often is notably delayed. It appears in some instances that the cardiac reserve is lost up to a point, often in childhood, and then remains stationary for years. Pulmonary infections may be troublesome complications. Cardiac arrhythmias arising in auricular ectopic foci have been frequently reported, and this occurred in three of the patients in this series. Examination showed cardiac enlargement and a systolic murmur at the pulmonic region. In auricular septal defect the pulmonary artery, with very rare exceptions, will be found enlarged. Right axis deviation completes those findings to be expected in most cases. These patients appear to be particularly exempt from bacterial endocarditis, and congestive heart failure is the common terminal event. The onset of failure is delayed long beyond the time when it is expected, and the condition responds to treatment better than is anticipated.

The cyanotic child will be found to have the tetralogy of Fallot, in the large majority of cases. Other congenital cardiac defects producing persistent cyanosis are rare. Cyanosis in the tetralogy of Fallot is associated with severe stunting of growth plus invalidism. Lack of oxygen, as reflected by deficient saturation of arterial blood, results in weakness and dyspnea which are not to be taken as manifestations of congestive failure but rather as failure of sufficient blood to reach the lungs. Polycythemia is a compensatory response to chronic oxygen unsaturation of the arterial blood and, to a certain degree, is to be expected in all cyanotic children. Clubbing of the fingers and toes is present if cyanosis and oxygen unsaturation of the arterial blood are sufficiently severe, but it was not noted in 4 of the 8 cases comprising the group. A rough systolic murmur often accompanied by a thrill usually is noted at the pulmonic area. Of the 8 cases in this series, a systolic murmur of only slight roughness was noted in 4, and a thrill was found in only 3. Right axis deviation in the electrocardiogram is a helpful sign, and was present in 4 of 6 cases in which this study was available. Cardiac enlargement may be present but is not regularly found. Persistent invalidism and a short life are to be expected in these patients. The Blalock-Taussig operation continues to result in a comparatively high mortality (17.7 per cent in a series of 610 cases) but the results in successful operations have been dramatic.[17] Although the defects in the heart are not corrected by the operation, and a new defect is added, the hazards of subacute bacterial endocarditis at the site of the anastomosis, and of cardiac enlargement due to the arteriovenous fistula created, have not as yet been great enough to seriously imperil the good results.

Aortic stenosis occurred in 2 cases in this series, and presented distinctive features. This is one of the very rare congenital deformities producing preponderance of the left ventricle and left axis deviation in the electrocardiogram. The rough systolic murmur with a thrill at the aortic area is diagnostic, and the transmission of this murmur to the apex of the heart is striking. These patients do well, and one of the two in this series has developed normally and continues active despite a blood pressure that has been practically imperceptible for several years.

The diagnosis of coarctation of the aorta has become more important in view of the good results achieved by Gross[18] in the surgical treatment of 100 cases, 71 of which were cured by resection of the coarctation, and 8 of which were improved. Sclerotic changes in the aorta render surgery hazardous after the age of 20, and early diagnosis is essential. The diagnosis in children often is not made because the condition usually is asymptomatic, also because the collateral circulation (identification of which is very helpful in the diagnosis) does not develop until about the age of 12 or 14. The hypertension which results from coarctation of the aorta primarily is a systolic hypertension, and the difference in the diastolic pressure in upper and lower extremities may not be noteworthy. Further confusion results from the fact that the systolic pressure in the upper extremities is not altered in some cases. The classical picture of hypertension in the upper extremities, with hypotension in the legs accompanied by demonstrable collateral arteries about the shoulder girdle and upper chest is unmistakable.

The cases in this series in which it has not been possible to arrive at a final diagnosis illustrate many of the difficulties encountered in the diagnosis of congenital heart disease. In some instances most of the observations have pointed

toward some congenital malformation but it has not been possible to reconcile them with other findings in the case. In other cases, the picture has been so confusing that only speculation has been justified. When we consider the great number of congenital malformations of the heart and great vessels which can occur either alone or combined, ample reason for these difficulties is evident. Several conditions have not been recognized in this series. Pure pulmonary stenosis has been suspected but the diagnosis has not been made. Lutembacher's syndrome was suspected in case 70 in which there was auricular septal defect but the findings did not justify the diagnosis. Truncus arteriosus, which was the diagnosis made elsewhere in one of our undiagnosed cases, had not been considered by us. The Eisenmenger complex was not suspected in any of these cases. The anomalies of the great vessels about the heart occasionally may be recognized, and they should be kept in mind always, but none has been suspected in this series.

It has been observed frequently that there is a strong hereditary tendency in the incidence of congenital heart disease. This tendency was present to a remarkable degree in the cases comprising this study. Two sisters (cases 53 and 57) had patency of the ductus arteriosus. A mother (case 49) had patent ductus arteriosus, and her child (case 77) had dextrocardia and an additional complicating lesion not identified. Another patient, a mother (case 58-B), has patent ductus arteriosus and is now 52 years of age, and her daughter, age 22 (case 58-A), has patent ductus arteriosus. The unusual hereditary tendency in patent ductus arteriosus has been reported by Walker and Ellis.[19] Two sisters (cases 68 and 69) had auricular septal defect.

In this group of patients auscultation of the heart was most helpful in case finding, and frequently provided diagnostic evidence. However, as the study progressed, and particularly in the examination of patients in whose cases the diagnosis was difficult, fluoroscopic examination of the heart invariably disclosed the most significant evidence. If fluoroscopy is done with patience and care, observations about the heart and great vessels can be made which frequently will prove vital in establishing the diagnosis.

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HIGH COST OF MEDICAL EDUCATION

The cost of education is of primary concern to all universities today, affecting the wealthiest as well as the poorest. This high cost applies most particularly to the study of medicine and the allied sciences, and, in the medical area, teaching and research in public health are suffering most severely. That this need must be met is obvious, because of the obvious fact that public health and preventive medicine represent the currents in which the medical practice of the future will flow.

The relations of a medical school to its affiliated teaching hospitals, themselves in straitened circumstances, need constant attention; these are among the problems raised in part by the prodigious strides that have been taken in the medical sciences.

The cost of the benefactions that science has brought to mankind must not be allowed to become prohibitive, nor must medical education become a captive branch of learning through the unguarded acceptance of those doles that eventually lead the way to universal "welfare."—New England Journal of Medicine.

DOUBLE ZIPPER SPONGE RUBBER COLLAR FOR IRON LUNG

(For Use in Emerson and Other Iron Lungs)

By E. BENNETTE HENSON, M. D.,
Charleston, W. Va.

For he past two years the Marmet Hospital, Marmet, West Virginia, has been using a double zipper flap sponge rubber collar designed by the writer to facilitate the placing of collar on to the neck of patient for the iron lung.

The heavy sponge rubber collar which comes as part of the equipment of Emerson and other iron lungs is cut from the center towards the periphery a distance of about 4½ inches in the same manner as one would cut a large pie. In this instance the slice cut is approximately 8 inches wide at the periphery. (Experimentally we have tried double flaps but found that they are of no particular value since this one opening allows ample room for a large head to be passed through without discomfort or anxiety). A pocket-book type of zipper is then sewed to the two cut margins which allows this quarter segment to be lifted up allowing the head to be passed through the collar without any difficulty whatsoever.

This zipper attachment has been tested up to twenty-two pounds negative pressure without any leaking of air through any part of the zipper attachment. The zipper material can be glued to the rubber and then sewed if one desires to make a more attractive job.

Fig. 1—The double zipper flap held open showing how easily child's head is brought through rubber collar.

After the patient is properly and comfortably placed in the iron lung the zippers can then be closed to any desired closure. (See Figs. 1 and 2).

I have found that patients become quite apprehensive when the collar fits snugly over the front part of the neck and are constantly asking that pressure be relieved because they are choking to death. With this new gadget the zipper can be released a notch or two and some cotton or other soft substance placed against the skin of the neck

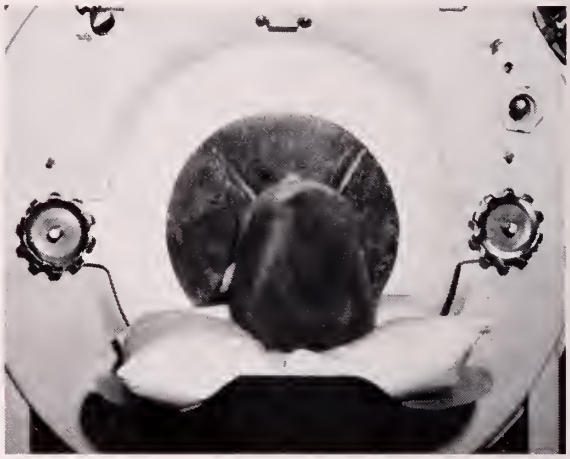

Fig. 2—Double zipper flap closed around patient's neck. This double zipper mechanism has been tested up to 22 pounds negative pressure without any leak.

relieving the patient's sense of suffocation. This has proved to be a most pleasant solution to the problem of apparent suffocation on the part of the patient. The cost of this additional material is less than a dollar.

This collar has been used in all of our iron lung cases during the past two years and has proved to be worthwhile.

MELLOWED JUDGMENT NEEDED

Medical science has ensured us a longer life expectancy. To make this long life profitable and interesting we must dignify the retirement years by offering changing interests for changing needs.

Continuous stimulus for intellectual participation will keep the older person abreast of the trends in this modern age. We must help him to grow in tolerance and understanding of the inter-relationships of the life around him.

If his physical activities must decrease because old age has brought decreasing physical strength, we must help him to recognize that he has earned the right to enjoy a less strenuous way of life and that we still need to have him share with us his mellowed judgment, his wisdom born of experience and contemplation.—Helen Noyes in Geriatrics.

THE TREATMENT OF OCCLUSIVE PERIPHERAL ARTERIAL DISEASE BY INTRA-ARTERIAL HISTAMINE

By W. C. SWANN, M. D., J. R. COOK, M. D., and W. K. YATES, M. D.
Huntington, W. Va.

The treatment of occlusive arterial disease has been an unsolved problem to medical science since its earliest recognition. However, some hope of a more effective treatment was offered by Mufson in the literature about a year ago.[1] With some innovations of our own, we have followed Mufson's method in the treatment of a number of these cases, with encouraging results. It will be the purpose of this paper to present the results.

We will first designate the types of peripheral vascular disease in which intra-arterial treatment may be effective. It is beyond the scope of this paper to cover the differential diagnosis in any detail. *Arteriosclerosis obliterans* is by far the most frequent type of peripheral arterial disease. Both males and females are susceptible. It is rarely diagnosed before the age of fifty. Arteriosclerosis obliterans constitutes a degenerative disease of unknown etiology affecting the large and medium sized arteries. It is assumed that hormonal and metabolic changes of senescence are the basis of this condition. The disease begins subintimally and progresses to the intima and media of the arterial wall. As a result, there are hyalinization, sclerosis and loss of elasticity. Although this is a generalized disease, there is a tendency to involve patchy areas.

Pain is the most frequent presenting symptom and often is misdiagnosed as "fallen arches" or rheumatism. The pain of arteriosclerosis is intermittent claudication and ischemic nerve pain. Walking pain is described by the patient as a dull ache or cramp, usually in the feet or calf. This pain is always relieved by stopping exercise for a few minutes. Following this episode, the patient usually can reproduce the pain with the same amount of exercise. Pain of other origin is not so readily relieved by rest. Ischemic nerve pain characteristically occurs when the patient is in bed. The pain usually is cramp-like and forces the patient to walk about for relief.

In addition to the foregoing symptoms there usually is reduced temperature of the affected limb, and color changes. In most cases these changes are not symmetrical. The palpation of peripheral pulsations and oscillometric studies are valuable diagnostic aids.

Thrombo-angiitis obliterans (Buerger's Disease) is a chronic arteritis and phlebitis, usually affecting middle aged men. In the advanced stages it causes gangrene of the toes, feet and lower legs. This is likewise a disease of uncertain etiology but inflammatory reactions have been considered as possible causative agents. This condition primarily involves the intima, and leads to thrombosis of the arteries and veins of the extremities. Consequently, there is reduction of blood flow to the involved area. While tobacco cannot be proven as an etiologic agent, it is almost impossible to alleviate this illness until the patient stops smoking.

Raynaud's disease is a functional disease, usually occurring in young women and affecting the upper extremities. The intermittent nature and the location of its effects make it a poor candidate for histamine therapy.

Erythromelalgia is the functional opposite of Raynaud's disease and is characterized by vasodilatation and redness of the extremities. This disease, which tends in itself to produce vasodilatation, of course would not benefit from intra-arterial histamine.

Other rare diseases which might benefit from intra-arterial histamine are the occlusive phases of pernio, trench foot, immersion foot and frost bite.

There have been many proposals advanced for the treatment of occlusive peripheral vascular disease. One treatment which temporarily received wide acceptance, the Pavex "boot", is based on the principle of alternate pressure and suction. This procedure is designed to force more blood into the leg. Results have not been too impressive, however, possibly due to the necessity of a tight cuff around the thigh to maintain the necessary pressure within the "boot".

Another method of treatment, and one of the most effective, has been the classic Buerger's exercises. A similar treatment which has given results is the oscillating or Sanders bed. These measures employ gravitational filling of the vessels of the extremities.

Intravenous typhoid antigen injections often will reduce the occurrence of rest pain in many cases.

Surgical procedures have been advanced for the treatment of these diseases. Sympathectomy offers definite help in some cases but it is a delicate operation and is associated with considerable pain, expense and inconvenience to the patient. Furthermore, if the sympathectomy is done too high, it is worse than useless, due to pooling of blood in the abdomen. Periarterial stripping operations have been very disappointing.

The fifth type of treatment, and probably the most widely used, is the administration of a vaso-

dilator. Papaverine, priscoline and nicotinic acid all have been tried, with varying results. It is assumed that the ineffectiveness of systemic vasodilators is due to their dispersal over the entire body instead of the desired local effect. Therefore, it seems logical to assume that local arterial injection of a vasodilator might give better results than systemic administration. After some consideration, it was decided that histamine was the most promising vasodilating substance. When given at a slow rate directly into the artery, a high concentration is possible in the affected leg but, due to tissue fixation, very little is available to institute a systemic reaction.

The administration of this treatment requires special equipment which can be assembled without difficulty. Due to the high intra-arterial pressure, it is necessary to force the fluid into the artery under pressure. This can be accomplished easily by attaching a manometer to the air space above the fluid reservoir. In this manner, the amount of pressure may be gauged. Under pressure the fluid passes through a Murphy drip into a special syringe equipped with an inlet in the side of the barrel.

The procedure of administration of intra-arterial histamine is as follows: The skin of the inguinal area to be treated is sterilized, the area draped, and the tissues over the femoral artery infiltrated with 2 per cent novocaine. Histamine acid phosphate 2.75 mg. is dissolved in 500 cc. of normal saline. The solution is then placed in the glass reservoir. One hundred mm. Hg. pressure is then exerted on the fluid and measured by the manometer. Great care must be exercised to eliminate all air bubbles from the system before injection is begun. As little as 2 cc. of air injected into the femoral artery may cause rather severe pain.

The femoral pulsation is located by careful palpation below the inguinal ligament and the needle is inserted slowly at a 45 degree angle, the needle point directed cephalad. As the arterial wall is reached a definite pulsation is transmitted through the syringe. When the needle enters the lumen of the artery, an immediate rush of bright red blood fills the barrel of the syringe and the plunger is thrust outward with each systole. As the plunger is forced to the limit of its extension, fluid is forced from the reservoir by air pressure. After the initial regulation of pressures, 2 to 5 drops pass through the needle during diastole and a pulsation of blood appears during systole. At the conclusion of the treatment one must be careful not to allow any air to enter the artery.

Immediately after beginning the treatment a histamine flush appears. This flush is first evident on the lateral aspect of the thigh. Finally, the knee is involved, and last of all the lower leg shows varying amounts of erythema. Concommitant with this flushing reaction there is a per-

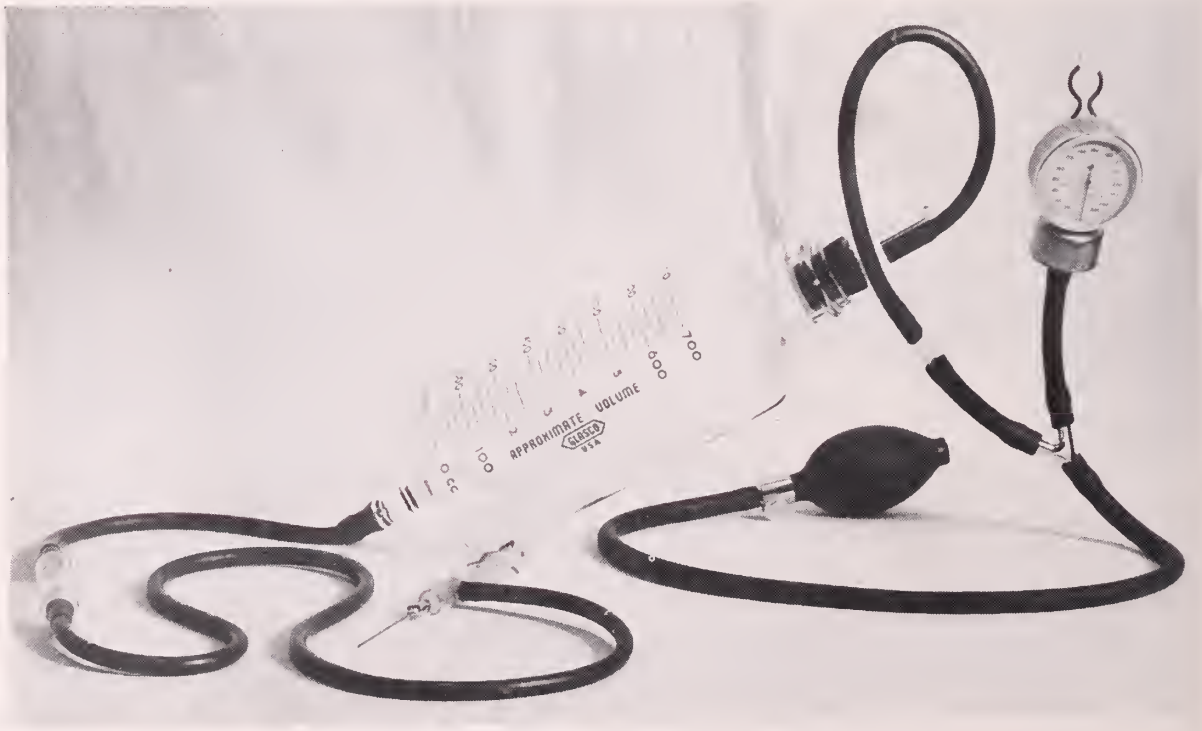

Fig. 1. Apparatus used for intra-arterial injection.

Fig. 2.

NAME	AGE	DIAGNOSIS	SYMPTOMS	NO. TREATMENTS Right	Left	ERYTHEMA	RESULT
1. Mrs. S.G.C.	79	A.S.O.*	Gangrene of the toes of the right foot.	4	0	Fair	Gangrene healed. Patient has since died of a mesenteric thrombosis.
2. Mr. J.W.M.	62	A.S.O. Coronary Heart Disease	Night pain. Pain on walking 100 ft.	3	3	Good	Able to walk at will. No more night cramps. Has since died of coronary occlusion.
3. Mr. G.W.D.	66	A.S.O. Diabetes	Night pain. Walking tolerance 2-3 blocks.	4	4	Good	No more night cramps. Can walk 10 blocks.
4. Mr. F.S.	53	A.S.O. Coronary Heart Disease	Walking tolerance 2-3 blocks.	5	4	Good	Can walk 10-12 blocks without trouble.
5. Mr. G.J.	77	A.S.O.	Night cramps and walking cramps.	5	5	Good	No more night cramps. Walking tolerance improved.
6. Mr. A.N.	54	A.S.O.	Walking pain left ankle.	0	6	Good in upper leg. Poor in ankle	Questionable improvement.
7. Mr. F.P.	78	A.S.O. Fungus infection left foot, refractory to all treatment	In view of refractory fungus infection and impaired circulation, it was decided the fungus could be treated more effectively if circulation could be improved.	0	5	Good	Fungus infection has improved markedly.
8. Mr. E.M.	62	A.S.O.	Walking tolerance 2 blocks.	2	5	Good	Now reports no trouble walking.
9. Mr. W.M.	58	A.S.O. Diabetes	Legs cold. Four blocks walking tolerance.	3	3	Poor	Developed gangrene left leg and had amputation.
10. Mrs. M.C.	73	A.S.O. Diabetes	Gangrenous area right ankle. Pain at rest.	5	15	Very Poor	Gangrenous patch has partially sloughed away. Still has cramps at rest.

*A.S.O. Arteriosclerosis Obliterans.

ceptible increase in warmth in the leg. This increase in warmth is evident to palpation when both legs are examined simultaneously.

Subjectively, the patient notices warmth in the treated leg and usually describes a "prickly" sensation. If the injection is given too rapidly, he may complain of a generalized reaction of this type. In our experience with this treatment, we have rarely initiated a histamine headache. The following table is included to demonstrate the results obtained in ten cases treated by this method. The subsequent case histories are included to illustrate certain observations the authors wish to mention.

Case 1.—Mrs. S. G. C., a 79 year old white female, was admitted to St. Mary's Hospital in August of 1948. Her diagnosis was arteriosclerosis obliterans and arterial thrombosis of the right leg with gangrene of the toes. She was treated with rest, penicillin, dicumerol and vasodilators. On Jan. 9, 1949 the patient was readmitted for intra-arterial infusion of histamine for treatment of obliterative arterial disease of the right leg. On Jan. 15, 1949 she was given another intra-arterial histamine treatment. The treatment was repeated Jan. 22 and 29, making a total of four treatments.

On Feb. 5, 1949 the patient was readmitted. The abdomen was distended, tympanitic and tender. The chest was clear. The heart showed auricular fibrillation (this condition had been present for several months). The patient was dehydrated. Vascular pulsations of both feet were imperceptible. On that day, the patient was operated upon and approximately ¾ of the jejunum was discolored and distended. The patient's condition did not permit resection. An enterostomy tube was inserted and the abdomen hurriedly closed. On Feb. 7, there was evidence of thrombosis of the left femoral artery, and left lumbar sympathetic block was done. It will be noted that the opposite leg was involved in the arterial thrombosis and that the treated leg had shown marked improvement. Despite various supportive measures the patient expired on Feb. 15, 1949.

Case 2.—Mr. J. W. M., a 62 year old white male with known hypertensive cardiovascular disease and arteriosclerosis obliterans was admitted to Saint Mary's Hospital on Feb. 10, 1949. He complained of walking pain and stated that he could walk no more than 100 feet without getting leg cramps. He complained also of night cramps in both legs. The patient was given three infusions in each leg over a period of six days. Following treatment the patient was able to walk at will without leg cramps. He was also relieved of night cramps. In March congestive failure and coronary insufficiency developed and he finally died suddenly as the result of coronary occlusion.

Case 3.—Mrs. G. W. D., a 66 year old white female with diabetes and arteriosclerosis was admitted to Saint Mary's Hospital Feb. 16, 1949 for intra-arterial histamine treatment. She had been troubled with night pain in both legs, especially the left, for several months. Her walking tolerance was 2 to 3 blocks. She was given a treatment each day in alternate legs for a total of four treatments in each leg. At the present writing, the patient has had no further night pain and can walk ten blocks without symptoms.

Case 4.—Mr. F. S., a 53 year old white male, came to Saint Mary's Hospital on March 6, 1949 complaining of pain in the left foot. The pain had begun one month previously and had continued at intervals. For the past three years the patient had been troubled with intermittent claudication and could not walk more than 2 or 3 blocks. He also gave a history of "vise-like" pain in the lower chest. He was given nitroglycerine tablets to relieve this pain. The diagnosis of arteriosclerosis obliterans was made. Esophageal electrocardiographic leads showed a definite old posterior myocardial infarct. This patient was given intra-arterial histamine five times in the left leg and four times in the right. Following discharge from the hospital and until the present writing the patient has experienced no further pain in the leg and can walk 10 to 12 blocks without difficulty. During a recent office visit, he described the results as "wonderful".

Case 10.—Mrs. M. C., a 73 year old white female with diabetes and arteriosclerosis, was admitted to Saint Mary's Hospital on November 2, 1949. The patient's history began in 1942 when the above diagnosis was made. At that time there was markedly impaired circulation in both lower extremities, and trophic changes were apparent at the left foot. It was feared that early gangrene might be starting. The patient was treated with Buerger's exercises and nicotinic acid. The discolored portion cleared as the diabetes was brought under control.

The patient subsequently discontinued insulin treatment and was seen again in 1948. At that time, oscillometer readings in the right leg below the knee were ¾° and in the left leg ½°.

In October of 1949 a gangrenous area developed on the lateral surface of the right ankle, measuring 4 x 6 cm. It was decided to try a course of intra-arterial histamine. Five treatments were given in the left leg and fifteen were given in the right. At the present writing part of the gangrenous area has separated and there has been no progression, although the patient is suffering rest pain.

CONCLUSIONS

It has been the purpose of this paper to discuss the authors' experience with intra-arterial histamine in the treatment of occlusive peripheral arterial disease.

Ten cases so treated have been included in a table presenting symptoms and results of treatment.

Case histories were selected from the table to illustrate the following observations:

1. Intra-arterial histamine is a valuable new method of treatment in occlusive peripheral arterial disease.

2. The presence of a good histamine flush at the onset of treatment is a valuable prognostic sign of the efficacy of treatment in a given individual. Conversely, the absence of erythema usually indicates poor collateral circulation and a poor final result from treatment. It is to be noted on the tabulated results of our cases that those patients who did not demonstrate erythema following histamine injection continued to experience ischemic symptoms and demonstrated progression of the arterial disease.

3. Patients in whom gangrene of an area has developed are likely to be benefited little by histamine therapy, especially in the absence of vivid erythema.

4. The duration or permanence of the benefit derived has not yet been determined. This we will attempt to analyze at a later date. A consideration of the value of this therapeutic procedure as compared with the benefits of surgical interruption of the sympathetic vassoconstrictor fibers is worthy of attention. The immediately demonstrable results are about the same for each of these methods. In so far as the comfort of the patient and the occurrence of undesirable effects of therapy are concerned, intra-arterial histamine is preferable to surgery. However, the crucial factor involved is that of the permanence of results.

5. The possibility that periarterial injection of novocaine might in itself produce vasodilatation in the extremity has been considered. In several of our cases, novocaine alone was used, the area of the femoral artery infiltrated but no intra-arterial histamine employed. This procedure did not produce either subjective or objective change in the extremity.

6. This treatment is an office procedure. We feel that it should be administered by the physician and the patient closely attended by him and not by the nurse or other attendant not completely familiar with the procedure. The chief danger would appear to lie in the inadvertent injection of air bubbles.

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THE BRITISH MEDICAL SITUATION

By E. B. RANDOLPH, M. D.,
Clarksburg, W. Va.

England has had a form of State Medicine since 1911. It was known as the National Insurance System or "Panel System" under which any person earning less than $750 per year was entitled to free medical care. This was extended prior to the last war to $1800. Panel doctors were those who contracted to care for these people on a voluntary basis and whose pay was based upon the number of patients on their panel, not to exceed $1500 a year. The funds were collected from taxation and left at the disposal of the Minister of Health.

Some of the defects of this system as the citizen saw them were that it did not include dependents, benefits were restricted and did not include specialists and institutional services, and there was a maldistribution of doctors. The profession was opposed to it because there was a lack of sufficient opportunity for teamwork and for securing specialist opinion other than at a hospital, and because there was insufficient remuneration for the amount of work done.

Early in the war, the British Medical Association in cooperation with the Royal College of Surgeons realized the advent of social upheaval resulting from the war and recognized the needs for reforms and improvements of medical services. It therefore set up a Medical Planning Commission to study the future of the medical services. In June 1942, the Commission issued its report intending to provoke criticism and discussion before it formulated definite plans. It did not make final recommendations, but set out the nature of the problems, discussed alternative solutions and made tentative proposals such as group practices by general practitioners, reorganization and distribution of specialist practice and hospital reforms.

In December, 1942, Sir Wm. Beveridge prepared a report on Social Security and allied services for the government. In it he stated the need for a comprehensive medical service that would reach all people regardless of income level, and stated also that the reorganization of medical service would need further investigation immediately.

Soon after this report, the Minister of Health invited the British Medical Association to set up a committee representative of the profession as a whole to discuss the problem. This was agreed to, provided that at the conclusion of the debate, before the plan was submitted to Parliament, the proposals could be given a complete airing before the societies and all members be given ample opportunity to express their views. From these discussions was drawn the famous White Paper upon which the present National Health Service is based. Its object is to insure every man, woman and child of getting advice, and thorough treatment and care in matters of personal health, and that such shall come from the best medical facilities available and shall not depend upon the patients ability to pay.

At best, any description of the administration is uninteresting but in order to understand why the doctors oppose the system, one must have a working knowledge of how it is governed.

The administrative structure is based on central and local authorities. The Minister is directly responsible to Parliament for the system. He is advised, when he deems advice necessary, by the Central Health Council which is composed primarily but not wholly of professional men appointed by the Minister. Attention is drawn to the fact that its members are appointed by the Minister who can be assured that their policies are in full agreement with his before appointment.

The Central Medical Board is the executive body, consisting primarily of doctors but, again, appointed by the Minister. It is their duty to serve as the employer with whom the doctors and dentists, contract when joining the service.

The Joint Health Authority is a combination of county and city councils elected by the people. It is their duty to examine the health needs, and to prepare and submit plans to the Minister. This body will be the owner of all government hospitals.

Under the Joint Health Authority come the Local Health Service Councils which study the local needs of the community and report their findings to the Joint Health Authority.

In considering the cost of the system, I found it difficult to translate it into dollars because of the fluctuation of the rate of exchange. I have used the present day figure of $4.00 to one pound sterling. This creates a discrepancy when dealing with prewar figures based on $3.00 to one pound sterling.

The Health Services were expected to cost $530,000,000. Of this amount, 143 million dollars were to come from Social Security funds, 193 million from taxpayers, and 160 million from rate payers who must pay the government for water, electricity and other utilities since all are government owned.

In what ways has the National Health Service affected the doctors? First of all, it was emphasized that no doctor was compelled to join.

However, it soon became apparent that he risked losing his practice in part or wholly to one who has joined. Obviously, the people are not going to pay twice for their care. As soon as the service became effective, July 5, 1948, 95 per cent of the people of Great Britian placed their names on the list of their doctor of choice. He could accept a maximum of 4000 names. If a hard working, efficient doctor has been customarily treating 8,299 people as was reported in one such case, he is penalized for his efficiency by the Executive Council which sent letters to those persons in excess of the maximum 4000, advising them to seek another doctor. This has a tendency to place all doctors, both good and bad, on the same level.

The physician becomes a civil servant in that his pay is based on the number of patients on his panel and is issued by the Minister. His rate of pay is $3.50 per person per year.

The doctor is governed by a long list of rules and regulations. When he enters the service he signs a binding contract with the government and any breach of contract now assumes gigantic proportions. Some of the terms of the contract are as follows:

1. He must give all professional advice and care within his competence.

2. He is subject to disciplinary machinery as set up by National Health Service. Any accusation of negligence on his part toward a patient is investigated by the Minister and if he is found guilty, his name is stricken from the medical register.

3. The government may terminate the contract at any time.

4. A new doctor must obtain the Board's consent to enter practice and his choice of locality will be granted if it is proven that a doctor is needed in that community.

5. Newly qualified doctors will be required to give full time to the public service in their early years if necessary.

Curiously enough, the remuneration of the specialist was not settled until March, almost a year after the service came into effect. All specialties are paid equally. After the specialist has obtained a staff appointment, his salary begins at $6,800. It is gradually increased to $11,000 at the end of eight years. At this point it remains, unless the doctor has exceptional ability or has made an outstanding contribution. If so, he is given a special ward of two, six and ten thousand dollars, depending upon those qualifications.

After only one year of application it is yet too soon to determine whether or not the Scheme as it is called there, has reduced sickness, or absenteeism which the government claimed made a form of National Health Program essential. However we can see what the cost is, likewise some opinions of the public and the profession.

Ordinarily, I do not feel that newspaper reports can be taken as facts, but during the past six months they have been under federal investigation having been accused of exaggeration and gross misrepresentation of facts. While under such investigation, I assume that there must be some basis for what they print. If we can judge from these reports, we can safely assume that rather than decreasing ill health and absenteeism, the Scheme has, on the contrary, increased them. Sickness is no longer a catastrophe, but rather a pleasant event. It is now anybody's privilege to go to the hospital free of charge; ambulance service is free, so it is used. Certainly food is better at the hospital than at home since here is one of the few places where meat can be gotten twice daily and milk three times daily. If the patient is not satisfied with his garments, the poor will issue a suit of clothes upon his discharge and return him home by ambulance. In our country a patient with fracture wants to go home as soon as possible to convalesce and help save expences. Not so in Britain; it is more economical for him to stay in the hospital.

On April 16, 1949, Sir Stafford Cripps, Chancellor of the Exchequer, reported to Parliament that for the first seven months the service had cost $816 million and the Minister of Health had asked an increase in budget of $212 million making a total of $1,040 million, almost twice the amount anticipated. The cost was expected to rise another $400 million for 1950.

Sir Stafford Cripps has refused any more money. However the slash in budget had already been felt. The hospitals suffered first. In February, the Minister announced that the hospitals were to cut their costs by $38,000,000. The result was that beds had to be closed down and some doctors were downgraded in salary. Dentists had been warned of a cut. The government now considers a token payment for each patient to "help finance the system and to bring home to the public that these services must be paid by taxation," a curious paradox after their propaganda of free medicine. (Briefly, may I point out where some of the cost goes). The Minister, defending his "baby" has admitted that the administration costs $23,920,000 or 2.3 per cent of total cost. I should imagine that under the strain of opposition this is indeed a conservative figure. In the first year $400 thousand were spent for

wigs; $1,600,000 for patients to go to Switzerland for convalescence. In the first six months 2,500,000 patients had sight tested, and 3,000,000 pair of glasses were issued. And, as I mentioned, free clothing has been added to the list of benefits for which no figures were available. Thirteen million dollars went for ophthalmic services.

These figures do not tell the whole story, however. The minister has promised a series of new clinics, yet the first of these will not be built until this fall. There are still 60,000 beds closed for lack of staff and personnel. The cost for opening these is expected to rise another $120,000,000. The average cost to the taxpayer is 7 cents out of the tax dollar (7 per cent).

As stated before, the people are not compelled to use the service, but since all must pay, the majority assume the attitude of "let's get while the getting is good." From the individual patient's standpoint it means waiting longer in the doctor's office or standing in line at the clinic. All patients are now clinic cases and treated as such. Medicine is doled out as off the assembly line for many feel that the doctor is no longer interested in his work.

If an operation is advised the patient's name is placed on a waiting list and at a later date he will be called for surgery. The length of this list is increasing. Elective surgical cases in Glasgow are now awaiting 2½ to 3 years. At King's College Hospital in London malignant tumors of the bladder are compelled to wait three months and, when they are admitted, many are inoperable according to Mr. Badenock, Chief Urologic Surgeon. There are now 90,000 people in the London area alone waiting for admission to the hospital.

The system has affected the doctors in many ways, all bad. In general practice he can no longer maintain an office, but uses his home. His paper work requires two secretaries to do the work that one ordinarily did. He has become a slave for the people rather than a servant. He is overworked and overwhelmed by people asking and demanding favors, sometimes using the implicit threat, "either you send what I want or I'll take my name off your list and let you starve."

To sum up the doctors reaction, let me read the following article. "We have been asked by our leaders to make the National Health Service a success, and this, I am sure, all reasonable and conscientious doctors have tried to do; but now at the end of one year of it, can we truthfully say that the average doctor is happy and content in his work? Some are better off financially; others are worse off; in many instances however, be they better or worse off, a subtle psychologic change has taken place. There is a "to-hell-with-it-all" attitude of mind. Why bother? Let them have what they want and don't let's have an argument." I believe from the information obtained after talking to some 45 doctors that this is typical of the attitude of our English colleagues. They have been tricked, cheated and defeated, and are resigned to the fact.

You may wonder why there is in existence a National Health Service if the situation is really as gloomy as the picture I have painted. Undoubtedly there are some people who are pleased with the system. If you ask the man on the street if he is in favor of free medicine, almost unanimously the answer will be "yes." If the same people are asked whether they are satisfied with the type of care they are getting, almost the same majority say "no." The answers one gets depends upon the way the question is asked. The Socialists are pleased with it because it is a political victory. Some misinformed reformists who sincerely think it is a service for humanity, are in favor; probably some of the younger medical men like the system because it guarantees a salary for their work. Patients who have paid less than one year's tax and enjoyed all the so-called free facilities like it, but I wonder if they will still bo so fond after they have paid for this year's operation over the next 10 or more years. By and large, however, the majority of people with whom I talked present the same gloomy picture that I have described.

The National Health Service is only a part of a vast rosy Socialist dream that the Welfare State can be paid for entirely by soaking the rich. The rich are all but soaked and it is Britain's plain people who are having to pay for their so-called free medical and social services through higher prices and higher taxation.

The nationalization of the health services is first on the time table of the Socialists' master plan. It is a well directed blow to the heart. A man cherishes his health and that of his family above all else. If the government can control this important phase of his life, then his power to resist further restriction will be destroyed. After the health service is controlled by the government, how about transportation, railroads, lawyers or public utilities? This fight isn't the fight of the doctors alone, but that of every man, woman and child in the United States who believes in American freedom. The sooner the people realize that socialized medicine is not the end but only the beginning of a plan to destroy that freedom, the sooner we will be in a better position to fight it. The handwriting is on the wall. All we need is to take its warning. A force

just as powerful, perhaps less brutal, but just as destructive as Communism, is threatening our liberties. We cannot be deceived into thinking that because it happened in England, it will not happen here. The trends are parallel.

We, in America, I believe have a tendency not to learn by the experiences of others. This is borne out by the fact that our system of free enterprise is paying for England's Socialist experiments. Realizing full well that our profits pay for her losses we still are being led by some up the same blind alley that our English friends have trod. If we are to learn from these experiences, then what are some of the lessons to be derived from the British Scheme?

In 1942, the Minister of Health presented to the profession a plan which he knew was extremely radical, which could not and would not be acceped by the profession. But by making small and minor concessions here and there, he gradually won first a few, then many to his way of thinking. To begin with, he had on his side a few doctors who had socialistic views of their own. These served as a firm foundation and their statements were quoted and requoted. By granting a livable wage to those seeking postgraduate training and hospital appointments, he won a few more. Formerly he had advocated dictatorial powers for the Minister, and by making concessions here, a few more were satisfied. By granting monthly salaries not too unjust to those of the upper age groups who contemplated retiring in a few years on a pension, he added more to his way of thinking until some 30 to 40 per cent of the doctors were not too much opposed to the system. The remainder, fearing to be left out completely, had no alternative but to join.

A second point may be made here. The hospitals are government owned under the old National Health Insurance Scheme, except for 200 small ones in all England, Scotland and Wales. Now in order for a doctor to practice his surgery, he must have a place to operate. That statement may seem naive but nevertheless it is fundamental. He has two choices, one to build his own private nursing home, which isn't very practicable nowadays; the other is to join the National Health Service and be appointed to the staff of a hospital. He cannot be on the staff of any government owned hospital unless he belongs to the health service. Our lesson here is obvious. One of our first lines of defense is the hospital. It is well known that too many hospitals in America are operating on a deficit. Should the government elect to take them out of the red by purchasing the hospital we find our bargaining power decreased. This is not a remote possibility, for this was the precipitating factor in initiating the old panel system.

A third point is well known by us all. Once any government gains a small amount of control it is only a question of time until it has complete control. The promises made now may be in good faith, but the subsequent Ministers of Health, or Federal Administrators, whichever the case may be, may have different views or a different interpretation of the same view, and to change the policy do not need the consent of the profession. Should the doctors have different views, they may not have the right of appeal or the right of arbitration, and such is now the situation in England. Our only alternative is to "strike," a term which we have avoided using in our negotiations. Neither is this a remote possibility. As of June 30, 1949, the British Dental Association refused to accept any National Health Service patients. The British Medical Association, while considering a similar proposal, has officially advocated that the members refuse to sign contracts for the coming year, a striking similarity to the "no contract, no work" phrase which is so common to our ears and eyes.

May I point out some differences in the British program from the one proposed by Oscar Ewing? First of all the government invited the British Medical Association into debate before it made definite recommendations. On the other hand, the advocates of socialized medicine in this country have refused the advice of the profession upon which the success of any national health service is 100 per cent dependent. They have assumed that the profession can be whipped into line to follow the bidding of a Socialist government.

Secondly, the cost of our system can in no way be compared with that of England. The total population of England, Scotland and Wales is 50,000,000 and covers an area less than the area of New York state. To multiply the cost there by 3, representing our 150,000,000 people would be only the beginning. In America the standard wage is higher, and the administrators (1,500,000 has been given as an approximate figure) would require a higher salary than their equivalents in England. There are 190,000 doctors compared with 20,000, all of whom must be paid for their services. And the construction of hospitals and clinics as proposed would complete an astronomical figure.

The medical services will be reduced to a figure far below the present standard or that of England under the National Health Service. Americans are free thinkers, and inclined to be rebellious against any sort of regimentation. I am convinced that if such a system is adopted

in this country it will involve our medical services in national ruin. A limit will be set by shortages of personnel and materials as well as the constant political fight for reduction in taxation and budget. As a result, medicine will be rationed and controlled, and there is no reason for supposing that nationalized medicine or state medicine possesses any moral superiority rendering it immune from the vices which rationing and control invariably bring in their trains.

There have been occasions when nations have been decimated by disease. They often have recovered by change in social structure. The Black Death, for instance, by creating a shortage of labor, destroyed the feudal system. In the 20th century civilization is faced with a threat unique in its history, the existence of more ill health than it can afford, due not to any temporary calamity, but paradoxically to the advance of civilization itself. Society has released new diseases of its own creation and with them new methods of treating all the diseases which it cannot cure.

We as a profession must not allow absorption in our daily round of office work to prevent us from counteracting the hysterical claptrap of demagogues and the false promises of academic theorists. We must remain united, preventing all attempts to divide our ranks, to carry the fight which we believe is right and just to its final successful end.

The medical profession has developed over the centuries as an independent profession. It has imposed upon itself strict standards and the whole foundation of its work is based on an atmosphere of scientific and intellectual freedom. Doctors have jealously fought for their freedom to work and to think their own way, to hold views which seem to them right and to practice their professions as they deem it to be in the best interests of their patients. The doctor's first allegiance is to his patient, and there has grown up a conception of doctor-patient relationship which is confidential and wholly personal. We are not prepared to sacrifice these things, and it is not in the public's interest that we should be asked to do so. We are not prepared to substitute obedience to the state for loyalty to the patient.

PREVENTIVE MEDICINE THE ANSWER

It is fine to be able to supply hospital beds, intravenous feedings, x-ray examinations and craniotomies for the victims of automobile accidents, but it would be even finer to be able to prevent a substantial number of the accidents. It is by means of preventive medicine —not by free medical care—that efforts to attain better national health are most apt to succeed.—New England Journal of Medicine.

PHYSICAL INDEPENDENCE OF OLD PEOPLE

There are two general aspects of the process of ageing that must be borne in mind in considering the physical independence of old people.

First there is a considerable gap between the official and the natural onset of old age. The official age may be taken as that at which contributory pensions first become payable—that is, 60 for women and 65 for men. The natural age may be taken as that at which the physical independence of adult life becomes so compromised that there is a definite limitation of activity.

The time of onset varies greatly from individual to individual, but the information available for old people living a natural life at home gives a clear answer, taking them as a whole. (1) The proportion who are fully ambulant sharply declines after 70; (2) the proportion who are confined to the house increases steadily after 70; (3) the number capable of carrying heavy domestic strains, such as the rearing of grandchildren, declines after 70, though the potential incidence of such strains increases with age; (4) 50% of women are engaged in the sole domestic care of their household up to the age of 70. At 75, 40% are so engaged, and thereafter the numbers fall rapidly to 18% at 80, and only 4% at 85.

Natural old age therefore makes itself felt in most people at about 70, and by 75 the process has acquired such momentum that only the exceptional individual escapes. There is therefore a period of five to ten years between the official and the natural onset of old age, and in the future it will be of the utmost importance that old people during this period should play an active part in life.—J. H. Sheldon, M. D., in British Medical Journal.

PRESENT STATUS OF AUREOMYCIN

The value of aureomycin in some virus and rickettsial infections is beyond dispute. It produces rapid improvement in lymphogranuloma inguinale; and so far, after six months or so, no relapses have been observed. In primary atypical (viral) pneumonia clinical improvement is noted in 12-48 hours.

Acute bronchiolitis or pneumonitis of infants, which is also probably a viral infection, responds to aureomycin better than to any other antibiotic or chemotherapeutic agent. Since auremycin is effective in the treatment of the bacterial as well as the nonbacterial pneumonias, it is probably the drug of choice whenever a case of pneumonia has to be treated without laboratory facilities. Its first trial in herpes zoster has been dramatically successful.

The virus of psittacosis is sensitive to aureomycin, but human cases are so rare that its effect on the clinical course of the disease is not known. Some cases of infective mononucleosis have shown a favourable response to aureomycin, but the drug is without effect in poliomyelitic, influenza, and the common cold.

Information on its value in variola and vaccinia is scanty; but it is not expected to be of value in these and other conditions caused by small viruses. Its action against rickettsial infections has now been clearly demonstrated in human Rocky Mountain spotted fever, epidemic typhus, murine typhus, Q fever, and rickettsial pox.—The Lancet.

The President's Page

It was my pleasure to sit in at the final meeting of our very efficient committee arranging the scientific program for the annual meeting at White Sulphur Springs, July 27-29. I understand that the complete program will be printed in the July issue of the Journal but that a news story in which the names of all the speakers will appear is being printed elsewhere in this issue of the Journal.

I sincerely hope that every member of the State Medical Association will study the program carefully with a view to attending as many of the sessions as may be possible. The program has been built with the greatest of care by Dr. James P. McMullen, of Wellsburg, the chairman, and Drs. Richard E. Flood, of Cove Station, Weirton, and E. J. Van Liere, of Morgantown, the other members of the committee.

Each day's session will in effect provide a refresher course for general practitioners as well as those engaged in the practice of a specialty. The speakers are prominent in their particular field, and the subjects for discussion have been chosen with a view to providing a program varied in character to appeal to all of our members.

We are told that accommodations are still available at the Greenbrier. We are promised by the management that everything possible will be done to take care of all doctors and their wives who wish to attend the meeting. However, due to the unprecedented demand for rooms during the summer months, it is imperative that reservations be made without delay. It is my earnest hope that there will be a large attendance of doctors and their wives when the annual meeting is officially opened early Thursday morning, July 27.

C. E. Watkins

President.

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THE 83rd ANNUAL MEETING

Although the annual meeting of the West Virginia State Medical Association will not be held until late in July, interest in the convention is being shown in every part of the state. The demand for rooms at The Greenbrier is heavy, but accommodations are still available for doctors and their wives. As this editorial is being written (May 17), reservations for the convention have been made at The Greenbrier by more than 350 doctors and their wives.

The scientific program was completed during the second week in May, and the list of speakers who have accepted invitations to address the general sessions literally reads like a "Who's Who in Medicine." The full program will be printed in the July issue of the Journal, but a general idea of the program for each day may be had by referring to the convention news story in this issue.

The work of the American Medical Association will be discussed by the president, Dr. Elmer L. Henderson, of Louisville, and a report on the AMA National Education Campaign will be submitted by Clem Whitaker and Miss Leone Baxter, who are in charge of the campaign. They will appear before the first meeting of the House of Delegates, July 27.

We hope that every member of the West Virginia State Medical Association will feel that this is one meeting that should not be missed. We congratulate the program committee, composed of Dr. James P. McMullen, chairman, Dr. Richard E. Flood, and Dr. E. J. Van Liere, for providing for this 83rd annual meeting a scientific program that will undoubtedly prove to be one of the best ever presented at an annual meeting.

ARE YOU REGISTERED?

"Politics and medicine don't mix!" Statements like this frequently are employed by many doctors to justify their failure to register, failure to vote and failure to take part in the political decisions of the local community, the State and the Nation.

Added to this viewpoint is the indisputable and somewhat extenuating fact that the best doctors are extremely busy people, engaged in the night-and-day task of preserving health and saving life.

DEADLINE, JULY 1

Voters must register on or before July 1 in order to cast their votes at the primary election in West Virginia, August 1.

Doctors, it is urged that you call your County Clerk's Office now to ascertain if you and your wife and other members of your family are registered. There will be no house-to-house canvass during 1950.

It is important now as never before that every person interested in medicine in any way register and vote both in the primary and general election.

Nevertheless, this year of decision, 1950, presents American doctors with an undeniable paradox: doctors either must enter the political arena or see politics enter medicine. For this is not just another election year. It is a year in which medicine itself will be one of the big clay pigeons on the political shooting ranges.

The question of Compulsory versus Voluntary Health Insurance, embodying the future not only of the medical profession but of all the American people, will be one of the principal issues in the 1950 Congressional elections. It is imperative, therefore, that every doctor exercise his franchise this year — his right as an individual citizen to register, to vote. Failure to do so may mean the ultimate termination of his traditional medical franchise, the right to practice medicine according to ethical professional and scientific standards, not political standards.

THE NEW DIABETES ASSOCIATION

Plans are progressing for the organization meeting of the new Diabetes Association, which will be held at White Sulphur Springs, Saturday afternoon, July 29, during the annual meeting of the West Virginia State Medical Association. A constitution will be presented for adoption at that time, and officers elected for the ensuing year. All members of the State Medical Association who are interested in the study of diabetes and the care of diabetics are urged to become members of the association at this initial meeting.

The prime purpose of the Diabetes Association is to disseminate information concerning the disease to members of the medical profession as well as the laity. It is planned for the association to sponsor open meetings with addresses to be given by doctors prominent in this particular field. Support will also be given to local diabetes detection drives each year during Diabetes week.

The diabetes committee of the West Virginia State Medical Association has already done an excellent job in obtaining facilities for a summer camp for diabetic children. Camp "Cliffside" has been donated by the Carbide and Carbon Chemicals Corporation, of South Charleston, for the week beginning August 26. Complete care for diabetic children will be assured through the full cooperation of camp counselors, medical attendants, laboratory technicians, and a dietician. Patients will pay no fee for attendance, the project being paid for by private donations from interested individuals and groups.

When the state association has been organized and the membership enlarged, much more can be done for the ever-growing diabetic population of West Virginia. Accomplishments such as these provide substantial selling points against compulsory health insurance.

We again urge all members of the State Medical Association interested in any way in the treatment of diabetes to become members of the new association.

ACADEMY PROGRAMS WORTHWHILE

If the attendance at the sectional meeting of the West Virginia Academy of General Practice, at Huntington, May 14, is indicative of the interest of general practitioners in scientific assemblies of this character, then the Academy may with full confidence plan for the other meetings that will be held in West Virginia during 1950.

The two speakers who appeared on the program at Huntington, Dr. H. P. O'Rear, and Dr. Samuel C. Martin, both of Duke University, Durham, North Carolina, presented interesting papers, and the more than sixty doctors present remained until the meeting adjourned late in the afternoon.

The next meeting will be held jointly with the Barbour-Randolph-Tucker Medical Society, at Elkins, on June 15, and invitations have been mailed to all parts of central West Virginia inviting doctors to attend the afternoon and evening sessions. The program appears elsewhere in this issue of the Journal.

Other meetings of the Academy will be held during the year at White Sulphur Springs, in July (during the annual meeting of the State Medical Association, July 27-29); at Wheeling, in September; at Beckley and Clarksburg, in October, and at Princeton, in November.

The officers, board of directors, and members of the West Virginia Academy deserve the thanks of doctors generally for arranging programs for meetings in various parts of the state that will enable those engaged in general practice to hear medical problems discussed by qualified speakers who are invited to participate in the sessions.

SCIENTIFIC MATERIAL NEEDED

The publication committee is in need of scientific material for the West Virginia Medical Journal. Doctors who are preparing papers for submission to the committee are urged to complete the work just as soon as possible so that papers may be considered for publication in the late summer, fall, and early winter issues.

Articles must be original, double spaced, and written on one side of paper only. References are limited to 25 and cuts to two per paper. A total of six cuts may be used, but the author will be required to pay for plates used in excess of two.

All papers should be mailed to Box 1031, Charleston 24, West Virginia.

THOUSANDS SEEK A MEDICAL EDUCATION

Our medical education is divided at the moment into three distinct periods, one of which we term premedical, a second, medical undergraduate period leading to the degree of M. D., and an increasing period devoted to what may be termed postdoctoral education, including the intern and residency programs.

At the present time there is certainly no lack of young men and women in this country who wish to follow the profession of medicine. Last year some twenty-six thousand individuals throughout this country made application to the medical schools which were able to accommodate somewhat less than six thousand. —C. N. Hugh Long, M. D., in Connecticut State Medical Journal.

GENERAL NEWS

PROGRAM RELEASED FOR 83rd ANNUAL MEETING AT WHITE SULPHUR SPRINGS

The final meeting of the program committee arranging the scientific program for the 83rd annual meeting of the West Virginia State Medical Association, was held at Weirton, Thursday afternoon, May 11, immediately preceding a joint meeting of the Hancock County Medical Society and the Brooke County Medical Society.

Dr. J. P. McMullen, of Wellsburg, presided as chairman at the meeting, which was attended by the other two members Dr. Richard E. Flood, Cove Station, Weirton, and Dr. E. J. Van Liere, of Morgantown. Also present were Dr. Charles E. Watkins, of Oak Hill, president of the West Virginia State Medical Association, and Charles Lively, of Charleston, executive secretary.

It was decided that general sessions will be called to order at 9:00 o'clock on the morning of each day of the meeting, which will be held at the Greenbrier, White Sulphur Springs, July 27-29. Section and society meetings will be scheduled for 2:00 o'clock the afternoon of each day. Night meetings will start promptly at 8:45 o'clock.

Meetings of the House of Delegates on July 27 and 28 will be called to order at 3:30 o'clock.

The registration booth will be opened at 3:00 o'clock Wednesday afternoon, July 26, on the main lobby floor at the Greenbrier, just outside the auditorium, and will remain open during each day of the meeting.

The pre-convention meeting of the Council is scheduled for 4:00 o'clock, Wednesday afternoon, July 26. There will be no formal program on Wednesday evening.

MCV Faculty to Present Program First Day

The first general session will be called to order Thursday morning, July 27, at 9:00 o'clock, by Dr. C. E. Watkins, the president. The entire program will be presented by members of the faculty of the Medical College of Virginia, Richmond. The discussion will be devoted to gastrointestinal diseases.

Dr. E. J. Van Liere, dean of West Virginia University School of Medicine, will preside at the session, and Dr. Kinloch Nelson, professor of clinical medicine and director of continuation education at the Medical College of Virginia, will serve as moderator.

The first speaker, Dr. James O. Burke, assistant professor of medicine, will discuss "The Treatment of Gastro-Intestinal Hemorrhage," and he will be fol-

Chase—Greenbrier Photo, White Sulphur Springs

The Casino Country Club at the Greenbrier, White Sulphur Springs, West Virginia, overlooks three perfectly groomed golf courses, all of which start and finish at the club. Pictured is the 18th hole.

The North Portico of The Greenbrier, West Virginia's world-renowned resort at White Sulphur Springs.

lowed by Dr. Carrington Williams, professor of clinical surgery, who will speak on "The Treatment of Benign Lesions of the Stomach and Duodenum."

Dr. Charles M. Caravati, assistant professor of clinical medicine, will present the case at a clinical pathological conference, and the pathology will be presented by Dr. F. L. Apperly, professor of pathology.

At the conclusion of the pathological conference, there will be a panel discussion of the papers presented during the morning session.

Second General Session

Dr. George M. Curtis, professor of experimental surgery at Ohio State University, will be the first speaker on Friday morning, July 28. His subject will be "Modern Treatment of Thyroid Diseases." He will be followed by Dr. Allan C. Barnes, professor of obstetrics and gynecology at Ohio State, who will discuss "The Use of Estrogenic Hormones in Clinical Practice." The program will close with a paper by Dr. Howard F. Polley, of the Mayo Clinic, Rochester, Minnesota, on the subject of "Investigations with Cortisone and Related Hormones in Rheumatoid Arthritis and Related Diseases."

Dr. Richard E. Flood, of Cove Station, Weirton, will preside as moderator at the Friday morning session, and a question period will follow the presentation of each paper on the program.

Third General Session on Saturday

The third general session will be opened on Saturday morning, July 29, by Dr. Philip Thorek, of Chicago, who will speak on "The Acute Abdomen." The second speaker will be Dr. H. B. Mulholland, professor of practice of medicine, University of Virginia Department of Medicine, Charlottesville, who will discuss "The Newer Insulins."

The third speaker, Dr. Earl H. Baxter, professor and head of the department of pediatrics at Ohio State University, will speak on "Common Respiratory Infections in Children." The last speaker at the Saturday morning session will be Dr. Frank H. Lahey, of Boston, who will discuss "Lesions of the Terminal Ileum, Colon and Rectum."

Dr. J. P. McMullen, of Wellsburg, will preside as moderator at the final general session and a question period will follow the presentation of each paper on the program.

Presidential Address First Evening

Dr. C. E. Watkins will deliver his presidential address on Thursday evening at 8:45 o'clock. Mrs. Dana T. Moore, of Parkersburg, president of the Woman's Auxiliary to the West Virginia State Medical Association, will also appear on the program.

AMA President Guest Speaker Second Evening

On Friday evening, Dr. Elmer L. Henderson, of Louisville, Kentucky, president of the American Medical Association, will be the guest speaker and will discuss "The Activities of the American Medical Association." Doctor Henderson's appearance will mark the first time that a president of the American Medical Association has visited West Virginia for several years.

Clem Whitaker and Leone Baxter Guest Speakers

The first meeting of the House of Delegates will feature addresses by Clem Whitaker and Leone Baxter, members of the firm of Whitaker & Baxter, in charge of the National Education Campaign of the American Medical Association. This meeting, which will be open to all members of the State Medical Association, members of the Auxiliary, and guests, will begin promptly at 3:30 o'clock, and will be followed by the formal first session of the House of Delegates.

Officers for 1951 will be elected at the second meeting of the House of Delegates on Friday afternoon, July 28. This meeting is also scheduled for 3:30 o'clock.

The feature attraction of the banquet on Saturday evening will be the appearance for the first time at a State Medical Association annual meeting of the Weirton Steel Male Chorus. This famous organization has appeared in many cities over the United States, and frequently broadcasts over national networks. There will be no formal address at the banquet, but golf and tennis trophies will be presented during the evening.

GOLF TOURNAMENT GOSSIP

The following "communique" from the Golf Committee is printed in its entirety for the benefit of doctors interested in participating in the medical golf tournament during the 83rd annual meeting of the West Virginia State Medical Association, at White Sulphur Springs, July 27-29:

It will be of interest to you to know that many beautiful and valuable prizes will be awarded to winners of the annual medical golf tournament which will be held during the 83rd annual meeting of the West Virginia State Medical Association at White Sulphur Springs, July 27-29.

Kloman Instrument Company, of Charleston, is offering a new grand championship trophy. You will recall that our own state president, Dr. Charles E. Watkins, of Oak Hill, retired the last "Kloman Cup" at the meeting last year.

Valuable prizes are also being awarded by the Max Wocher and Son Company, Cincinnati; McLain Surgical Supply Inc., Wheeling; The Medical Arts Supply Co., Huntington; Feick Brothers Company, Pittsburgh; and Kloman Instrument Company, Charleston.

It will not be necessary for you to furnish your handicap rating. Just bring your golf equipment and the committee will take care of the rest.

Play will be limited to afternoons on July 27-28-29, and you may play either on course No. 1 or course No. 3. Participants must notify starter when play has begun, and play must be in threesomes or foursomes. Each participant must keep his own score and count all putts.

If you play golf, you are urged to bring your clubs and join in the fun.

The Golf Committee which will have charge of the tournament is composed of Dr. R. R. Summers, of Charleston, chairman, and Drs. Olin T. Coffield, of New Martinsville, and R. O. Halloran, of Charleston.

BARBOUR-RANDOLPH-TUCKER SOCIETY AND GP ACADEMY IN JOINT MEETING

A joint meeting of the Barbour-Randolph-Tucker Medical Society and the West Virginia Academy of General Practice will be held Monday evening, June 15, at the Tygarts Valley Country Club, near Elkins.

Dr. Hu Myers, of Philippi, will preside at the scientific session which is scheduled to begin at two o'clock. The following program will be presented:

"Preventing Medico-Legal Pitfalls." — Mr. Rex Roth, Wheeling.

"The Early Diagnosis of the Acute Abdomen."—Warfield M. Firor, M. D., Baltimore.

"Diarrhea in Infants."—McLemore Birdsong, M. D., Charlottesville.

"Recent Advances in Hematology."—Milton S. Sacks, M. D., Baltimore.

Each address will be followed by a question and answer period, with questions to be addressed to the chairman from the floor.

A banquet will be served at the Country Club at 6:30 o'clock with Mr. Thomas H. Hendricks, secretary of the AMA Council on Medical Service, as the guest speaker. Charles Lively, executive secretary of the State Medical Association, will serve as toastmaster and will be introduced by Dr. Charles L. Leonard, president of the B-R-T Medical Society.

Interesting medical sound pictures will be shown immediately following the speaking program.

A general invitation has been extended to West Virginia doctors to attend this joint meeting, which will be the first of its kind ever held in the state.

DOCTOR REVERCOMB HONORED

Dr. Paul H. Revercomb, of Charleston, was elected governor for West Virginia at the annual meeting of the American College of Physicians, at Boston, April 20. He succeeds Dr. D. A. MacGregor, of Wheeling. The term is for three years.

Dr. William S. Middleton, of Madison, Wisconsin, is president of the College. The next meeting will be held in St. Louis, April 9-13, 1951.

W. VA. PUBLIC HEALTH CONFERENCE ELECTS

Mrs. Olive Snyder, of Fairmont, was elected president of the West Virginia public health conference at the 26th annual meeting, held at Wheeling, May 4-5. Other officers were elected as follows: First vice president, A. Glenn Evans, M.D., Fairmont; second vice president, Lester S. Kyle, Charleston; treasurer, Mrs. Katherine Jones, Charleston; and delegate-at-large, Mrs. Florence Sperow, Morgantown, Charles Lively, Charleston, and W. H. Rost, Charleston.

HEART CLINIC EXPANDS SERVICES

The services available at the Heart Clinic of the West Virginia Heart Association, held weekly at the Kanawha-Charleston Health Department, have been expanded to include treatment as well as diagnosis. The clinic is being operated primarily for the benefit of indigent and medically indigent patients.

STATE HOSPITALS RECEIVE FEDERAL FUNDS

The new Charleston Memorial Hospital Association, and the Herbert J. Thomas Memorial Hospital, South Charleston, received checks on May 15, totaling $247,-653.37, being West Virginia's first grant under the Hill-Burton Hospital Construction Act.

The Charleston Memorial Hsopital received $228,-096.93, and the Herbert J. Thomas Memorial Hospital, $19,556.44.

The total cost of the 129-bed unit of the Charleston Memorial Hospital is estimated at $4,566,843, with one-third of the amount, $1,522,281 to be represented by a grant from the government for hospital construction.

The grant to the Herbert J. Thomas Memorial Hospital was made for construction of the new nurses' home and the renovation of the top floor of the hospital, which will provide an additional 28 beds. The total cost will be $103,251, with federal grants totaliing $34,-317.

Under the federal regulations, the first installment of a grant from the government under the hospital construction act is made when not less than 25 per cent of construction of the building has been completed. The second installment is paid when the mechanical work has been substantially roughed in, and the third when work under the construction contract is completed and final inspection has been made by the state and federal agencies.

According to Dr. N. H. Dyer, state director of health, several applications for federal funds for hospital construction have been received during the past year. Approval of the applications will be made according to the priority schedule set up in the state plan.

PROPOSED AMENDMENT TO THE CONSTITUTION

The following amendment to the Constitution of the West Virginia State Medical Association, offered by Dr. C. B. Wright, of Huntington, at the annual meeting of the House of Delegates at White Sulphur Springs, August 4-6, 1949, will be submitted to the House for final action at the 83rd annual meeting at White Sulphur Springs, July 27-29, 1950:

Article V

Sec. 1. Amend the section to read as follows:

"The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) delegates elected by the component county societies; (2) ex-presidents for a period of three years following their tenure of office; and (3) the president *ex officio*."

(This section now reads as follows: "The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) delegates elected by the component county societies; (2) all ex-Presidents; and (3) *ex-officio*, the President.")

DR. CHARLES T. ST. CLAIR HEADS WEST VIRGINIA ACAD. OPH. AND OTOL.

Dr. Charles T. St. Clair, Jr., of Bluefield, was elected president of the West Virginia Academy of Ophthalmology and Otolaryngology at the spring meeting held jointly with the Virginia Society at White Sulphur Springs, May 8-9. He succeeds Dr. Garnett P. Morison, of Charles Town.

Dr. A. C. Chandler, of Charleston, was named president elect; Dr. Melvin W. McGehee, of Huntington, second vice president; Dr. Ben W. Bird, of Princeton, secretary; and Dr. John B. Haley, of Charleston, treasurer.

The joint meeting was attended by over 100 members of the two societies from Virginia and West Virginia. The following West Virginia doctors were registered:

R. Alan Fawcett, Wheeling; Parker H. Lee, Jr., Bluefield; Charles E. Watkins, Oak Hill; H. W. Angell, Charleston; W. J. Judy, East Rainelle; James P. Baker, White Sulphur Springs; Albert C. Esposito, Huntington; R. M. Ferrell, Ronceverte;

William F. Beckner, Huntington; Ben W. Bird, Princeton; James E. Blaydes, Bluefield; Carl F. Breisacher, Charleston; A. C. Chandler, Charleston; Carroll A. Davis, Logan; Claude R. Davisson, Weston; James W. Frazier, Charleston;

Thomas M. Goodwin, Elkins; John B. Haley, Charleston; Sobisca S. Hall, Clarksburg; Eugene C. Hartman, Parkersburg; Henry C. Hays, Williamson; Virgil E. Holcombe, Charleston; J. A. B. Holt, Charleston; Nime K. Joseph, Wheeling;

Melvin W. McGehee, Huntington; Ralph McLaughlin, Charleston; Garnett P. Morison, Martinsburg; G. R. Mullens, Logan; Frederick C. Reel, Charleston; Harry T. Schiefelbein, Welch; W. F. Shirkey, Jr., Charleston; Frank B. Snell, Montgomery;

James T. Spencer, Charleston; Harry V. Thomas, Clarksburg; George H. Traugh, Fairmont; and John H. Trotter, Morgantown.

DOCTOR DYER CONSULTANT TO USPHS

Dr. N. H. Dyer, state director of health, has been appointed special consultant to Surgeon General Leonard A. Scheele and other officials of the U. S. Public Health Service.

Doctor Dyer, together with seven other health officers in the United States, will be on call for consultant service limited to 130 working days in any fiscal year. The health officers chosen for consultant service comprise the executive council of the Association of State and Territorial Health Officers. Doctor Dyer was elected a member of the Council in 1949.

HEART ASSOCIATION OPENS OFFICES

The West Virginia Heart Association has opened offices at 1013 Quarrier Street, in Charleston, with Mrs. Caroline R. Rainbolt in charge as executive secretary.

Dr. John E. Stone, of Huntington, is president of the Association, and the other officers are Dr. Lawrence Gang, of Huntington, vice president; Dr. Fred Richmond, of Beckley, secretary; and Dr. Wade Rardin, of Beckley, treasurer.

STATE SECTIONS OF S. E. SURG. CONGRESS PLAN JULY SESSION AT THE GREENBRIER

A meeting of sections of the Southeastern Surgical Congress from the District of Columbia, Maryland, Virginia and West Virginia, will be held at the Greenbrier, White Sulphur Springs, July 13-15. The following program has been arranged for the three-day meeting:

Thursday, July 13

"Nasal Fractures"—W. Raymond McKenzie, M. D., Baltimore.

"Control of Pain by Intravenous Narcotics, Nerve Block or Ethyl Chloride Spray"—Donald Stubbs, M. D., District of Columbia.

"Gastric Surgery"—J. M. Emmett, M. D., Clifton Forge, Va.

"Surgical Treatment of Lung Abscesses"—M. L. White, Jr., M. D., Huntington.

Friday, July 14

"Open Reduction of Fractures"—C. C. Howard, M. D., Glasgow, Kentucky.

"Duodenal Obstruction in the Newborn"—J. O. Rankin, M. D., Wheeling.

"Tantalum Mesh in the Repair of Ventral and Inguinal Hernia"—Amos R. Koontz, M. D., Baltimore.

"Diseases of the Gallbladder"—Frank S. Johns, M. D., Richmond, Virginia.

Saturday, July 15

"Treatment of Fractures of the Hip with a New Type of Adjustable Leg Screw Bolt"—O. S. Loyd, M. D., Baltimore.

"The Problem of the Female Bladder with a Normal Urine."—Charles A. Hoffman, M. D., Huntington.

"The Diagnosis and Treatment of Massive Upper Gastro-Intestinal Lesions"—Herbert Schoenfeld, M. D., Washington, D. C., and Aubrey O. Hampton, M. D., Washington, D. C.

"Evaluation of Cytologic Studies in the Early Diagnosis of Cancer"—Richard A. Michaux, M. D., Richmond, Virginia.

Rush D. Holt, of Weston, former United States Senator from West Virginia, will be the guest speaker at the banquet Saturday evening, July 15. The subject of his address will be "Fable of the Free Lunch." Separate business meetings of the four state sections will be held at noon on July 14.

Dr. E. Lyle Gage, of Bluefield, president of the West Virginia section, will preside at the general session on July 13. Doctor Gage was elected to succeed Dr. R. K. Buford, of Charleston, at the annual meeting of the Southeastern Surgical Congress last March.

Dr. C. C. Howard, of Glasgow, Kentucky, who will present a paper on July 14, is president of the Southeastern Surgical Congress. He succeeded Dr. R. J. Wilkinson, of Huntington.

INTERNATIONAL CONGRESS ON CHEST DISEASES

The First International Congress on Diseases of the Chest will be held at the Carlo Forlanini Institute, Rome, Italy, September 17-22, 1950. One hundred speakers from all parts of the world will cover every phase of our present knowledge of diseases of the chest.

The Congress is sponsored by the Council on International Affairs of the American College of Chest Physicians, and the Carlo Forlanini Institute, of Rome.

RURAL MEDICAL CARE THEME OF CONFERENCE AT JACKSON'S MILL

The first statewide rural health conference, sponsored by the West Virginia State Medical Association, and held at Jackson's Mill, May 18, resulted in assurances being given essentially rural communities that it is possible to build and maintain a small hospital even without state or federal aid.

The meeting, which was in charge of the Association's public relations committee, got away to an early start in the assembly hall at the State 4-H Camp. Dr. Frank J. Holroyd, chairman of the committee, presided at both morning and afternoon sessions. The meeting had been carefully planned so as to provide adequate time for a rountable discussion of problems presented by the four speakers.

Community Carnerstanes

Dr. George F. Bond, head of the Valley Clinic and Hospital at Bat Cave, North Carolina, told nearly a hundred representatives of rural groups and professional and lay organizations the story of the building, against great odds, of a 12-15-bed clinic and hospital at Bat Cave, in Hickory Nut Gorge, not far from the famed Chimney Rock in his home state.

The project was strictly a community affair built by the people themselves without any outside financial aid. The brick building was originally used as a school, and the structure was remodeled and dedicated as a hospital in 1948, since which time over 300 babies have been delivered there. "The four cornerstones of any community," said the speaker, "are the churches, family life, educational facilities, and medical facilities."

Centralization Brings Problems

The speaker discussed the plight of rural areas as the result of concentration of churches in larger areas, centralization of rural school systems, and finally the loss of the country doctor. Answering the question, "what can be done to build back this now forgotten idea of medical service, or the service of a country doctor," Doctor Bond stated that the availabilty of modern facilities would do much to attract general practitioners in rural areas. Such facilities would enable them to practice medicine the way they were taught. "Doctors stay out of the country," he said, "only because they don't want to get a decent Class A education in 1950 and go back into the country and practice 18th century medicine."

Another point made by the speaker was that a clinic or hospital in a rural area should be built "from the community up and not from Washington down."

The speaker suggested that it is possible for a rural practitioner to take care of 85 per cent of the people in his community at a small clinic or hospital, with the remaining 15 per cent being referred to hospitals close by. "Too many communities," he said, "feel that if they are going to build a hospital it must be another John's Hopkins."

Doctor Bond strongly advocated early immunization for children. Immunization at his clinic, he said, starts at six weeks and is finished in six and one-half months. He reported that he had not had a case of diphtheria among his patients for over four years.

Community Health Centers Needed

In addition to the construction of small community health centers as the answer to the doctor shortage in rural areas, Doctor Bond stated that every effort should be made to sell Blue Cross and Blue Shield plans to the people of a rural community. "If the rural people will not accept the Blue Cross plan," he said, "it is because of a lack of proper education on the part of doctors, hospitals, and nonprofit plans themselves.

The speaker praised public health personnel for the work that is being done in rural areas and asked for full cooperation of the medical profession in the program of the state department of health.

Doctor Bond believes in hospital delivery of babies and recalled that 1948 statistics show that three out of every five babies born in West Virginia were delivered in a hospital. "If we can obtain 100 per cent hospital deliveries," he said, "then the maternal mortality in child birth will be practically zero."

State Pragroms Should Be Balanced

Dr. H. B. Mulholland, of Charlottesville, professor of practice of medincine and assistant dean of the University of Virginia Medical School, reviewed some of the work of the AMA committee on rural health and council on medical service. He is a member of both groups. He believes that all state programs should be properly balanced and that appropriations for education should be combined with those made for medical care so that the two programs would always be in balance.

"The best place to teach the essentials of good health is in the schools," he said. Health instruction should include the proper care of the teeth and information concerning nutrition. He placed the importance of a good school lunch almost above everything connected with education. "We must demonstrate to our children and their parents in a practical way the advantages of good nutrition," he said.

State Health Cauncils Needed

He stated that the job of educating our people in health matters cannot be done in Washington or in Charleston, but must be attended to "right down in the communities themselves." He said that one of the best ways to solve all of the problems of rural health and medical care is through a health council, which should not be called a rural health council, but a state health council. He said that medical care is not just a county problem but the problem of a whole given area.

Women Can Spark Program

He called upon the women of rural communities to develop the idea of a health council because "the women can spark the program." He suggested that it will be necessary for each state to develop a rehabilitation center for our old people, including those who are paralyzed or afflicted with other degenerative diseases. This is necessary, he said, because all of the time we are getting more and more old people. "We

must have places where these old people can get decent medical care," he said, "and in most instances they will not need special nursing care because they can be taught to take care of themselves."

Roone County Survey

Miss Gertrude Humphreys, state leader of home demonstration work, agricultural extension service, West Virginia University, submitted a spot study that had been made of the needs for medical and hospital service in a typical rural county. The study was made in Roane county by selected groups of rural people under the direction of the agricultural extension service.

Miss Humphreys stated that Roane county was selected for this study because it was felt that it is really a typical county, and, further, that rural groups were organized there which could and did help in the survey. Another deciding factor was the real interest of the farm people there in doing something to improve the health of those who reside in rural communities. Extension workers generally aided in the survey, and the work was completed through the farm women's clubs."

Questionnaires were mailed to farmers in the various areas of the county and about 300 replies were received.

Matters such as adequate medical and hospital care, availability of doctors, hospitals, nurses, dentists, and medical and hospital insurance, age of doctors, fees, and night calls were covered in the questinnaire.

Preparing Report

A written report is now being prepared by Miss Humphreys, which will be published in full in the West Virginia Medical Journal in an early issue that will be devoted to rural medical care and which will include the papers presented by the other speakers on the program.

Miss Humphreys, in summing up, stated that "we hope that this survey may point the way to some of the things we can do to improve health conditions in our rural areas.

Preventive Medicine Important

Dr. N. H. Dyer, of Charleston, state director of health, told the representatives present at the meeting that preventive medicine is one of the most important things in rural health. "We are planning to work toward total health in West Virginia," he said. "We have been striving desperately through the years to prolong life. Since 1900 we have increased the span of life by 20 years. We want to keep the old people with us as long as we can and make them comfortable. We may not be able to meet that challenge completely, but at least we can try and we are trying."

Community Health Centers

The health director said that the state department of health had arranged a priority rating for 22 community health centers in West Virginia. "This," he said, "will be a beginning." Federal funds will be available year by year for two years, and under the amended Hill-Burton bill that has been passed by the House of Representatives and is now pending in the Senate, federal funds will be available for hospital, clinic, and health center construction on the basis of 62.29 federal funds to 37.71 local funds.

Doctor Dyer said that eleven state projects are now ready for construction with funds made available through the Hill-Burton act. Commenting upon the lack of doctors reported in the survey submitted by Miss Humphreys, he said that there is one physician for every 2,000 people in Roane County, while the average for West Virginia is one for every 1,400 people. The national average is one doctor for every 700 people.

Increase in Federal Funds Possible

If the new allocation of funds provided for in the bill pending in the Senate is made, Doctor Dyer said that West Virginia will have a nest egg of approximately five million dollars for construction of hospitals of from 25 to 75 beds in various high priority communities in West Virginia. The speaker pledged the continued aid of all state and local health officials in finding an adequate solution for the problems of medical care in our rural communities.

Four-Year School Solution to Problem

The meeting was closed with a roundtable discussion which resulted in many questions being propounded from the floor. The four speakers on the formal program served as an informal panel to discuss the questions raised, and several members of the group, including Dr. Frank J. Holroyd and Dr. C. E. Watkins, president of the West Virginia State Medical Association, insisted that the only real solution to the doctor shortage in our rural areas is for us to educate more doctors who will locate for practice in this state. This, they insisted can be done only through the creation and maintenance of a four-year school of medicine and dentistry in West Virginia. They pleaded for help among all the groups present in carrying this fight to the legislature in 1951.

Report to be Submitted

The matters discussed at the conference will be submitted to the medical profession generally in the report that will be made by Doctor Hoyroyd and the other members of his committee to the State Medical Association's House of Delegates at the annual meeting at White Sulphur Springs, July 27-29. It was understood that the other representatives present will report the results of the conference to their respective groups.

While no date was set for another conference, the hope was expressed that the various plans for rural medical care discussed at the meeting can be studied sufficiently to permit some concrete action to be taken later on in the year.

The Association has no rural health committee, such committee having been merged with the publicity committee under the name of public relations committee. Doctor Holroyd has served as chairman of the new committee for the past two years. Besides the chairman, the committee is composed of Drs. James S. Klumpp, Huntington, John F. McCuskey, Clarksburg, Athey R. Lutz, Parkersburg, Clark K. Sleeth, Morgantown, Francis J. Gaydosh, Wheeling, and Guy H. Michael, Parsons.

SCIENTIFIC ASSEMBLY AT HUNTINGTON SPONSORED BY W. VA. ACAD. GEN. PRAC.

More than sixty general practitioners were registered at the scientific assembly sponsored by the West Virginia Academy of General Practice, held at Huntington, May 14.

The morning session was devoted to a discussion of "Gastro-Intestinal Diseases," with Dr. James L. Patterson, of Logan, presiding.

Dr. H. B. O'Rear, of Durham, North Carolina, presented a paper on "Common Gastro-Intestinal Disorders." He was introduced by Dr. Victor Politano, of Milton, and the paper was discussed by Dr. Thomas G. Folsom, of Huntington, and Dr. J. Paul Aliff, of Charleston.

Dr. Samuel Martin, also of Durham, North Carolina, was the speaker at the afternoon session. His subject was, "Common Respiratory Disorders." Dr. T. Maxfield Barber, of Charleston, presided at the session and Doctor Martin was introduced by Dr. C. Stafford Clay, of Huntington. The paper was discussed by Dr. Richard J. Stevens, of Huntington, and Dr. Raymond A. Updike, of Montgomery.

Area meetings of the Academy are planned for Elkins in June; White Sulphur Springs, July; Wheeling, September; Beckley and Clarksburg, October; and Bluefield, November.

Dr. James L. Patterson, of Logan, is president of the Academy, Dr. Donald R. Roberts, of Elkins, vice president, and Dr. Carl B. Hall, of Charleston, secretary-treasurer.

The Board of Directors is composed of Dr. T. Maxfield Barber and Dr. J. Paul Aliff, of Charleston, and Dr. Jacob C. Huffman, of Buckhannon.

The following West Virginia doctors were registered at the meeting:

S. R. Hoover, Huntington; Harlan A. Stiles, Huntington; R. B. Richmond, Huntington; William C. Polsue, Charleston; H. H. Farley, Logan; Clarence H. Plymale, Huntington; Thomas J. Holbrook, Huntington; W. J. Porter, Wayne; John Hartford, Rensford;

J. A. Guthrie, Huntington; W. F. Daniels, Huntington; W. J. Glass, Jr., Charleston; J. T. Peters, South Charleston; N. F. Hines, Huntington; F. X. Schuller, Huntington; E. B. Gerlach, Huntington; Walter E. Vest, Huntington; L. C. Richmond, Milton;

C. G. Willis, Huntington; E. V. Henson, Charleston; H. H. Howell, Madison; Frank M. Booth, Huntington; R. H. Curry, Barboursville; O. L. Quillen, St. Marys; L. W. Frame, Huntington; Robert S. Barrett, Huntington;

John E. Stone, Huntington; G. C. Morrison, Huntington; Thomas G. Folsom, Huntington; Oscar B. Biern, Huntington; C. G. Polan, Huntington; C. O. Reynolds, Huntington; William E. Irons, Huntington; W. P. Smith, Huntington;

George W. Walden, West Hamlin; Thomas M. Barber, Charleston; Howard G. Bateman, Williamstown; Benjamin V. Blagg, South Charleston; Thomas H. Blake, St. Albans; William D. Bourn, Barboursville; Dennis J. Cronin, Huntington;

Edwin A. Davis, Charleston; Ellery T. Drake, Williamson; Claude Frazier, Huntington; P. A. Haley, II, Charleston; Carl B. Hall, Charleston; Leonard Iverson Hoke, Nitro; Arthur C. Litton, Charleston; Liskie J. Moore, Huntington;

V. A. Politano, Milton; James W. Repass, Lumberport; Donald R. Roberts, Elkins; C. Carl Tully, South Charleston; Halvard Wanger, Shepherdstown; John W. Newman, Affinity; James L. Patterson, Logan;

George W. Speed, Mullens; Raymond A. Updike, Montgomery; Ward Wylie, Mullens; S. J. Levine, South Charleston; and Goff P. Lilly, Charleston.

OPENINGS FOR DOCTORS IN STATE

The State Medical Association is still receiving requests for "relief doctors" for temporary work, as well as requests for doctors for permanent locations in various parts of the state. In order to help publicize the places where there is an acute shortage of doctors, information concerning locations will be published frequently in the Journal.

Openings for doctors have recently been reported in the following cities and towns in West Virginia:

Auburn	Iaeger
Beards Fork	Keystone
Belington	Lumberport
Berkeley Springs	Matoaka
Bradshaw	Montgomery
Cairo	Mullens
Cass	Nellis
Circleville	Oak Hill
East Gulf	Quinwood
Ellenboro	Salem
Gary	West Union
Glen Rogers	Whitesville
Hundred	

Names of doctors, persons, or groups reporting openings in various West Virginia communities may be obtained by writing the West Virginia State Medical Association, Box 1031, Charleston 24, West Virginia.

ANNUAL TENNIS TOURNAMENT

The tennis committee appointed by Dr. Charles E. Watkins, president of the State Medical Association, for the purpose of arranging the tennis tournament in connection with the annual meeting at White Sulphur Springs, July 27-29, has announced that the Kloman Instrument Company, of Charleston, has offered a trophy, which must be won three years by a doctor before it becomes his permanent possession. The trophy will be on display at The Greenbrier during the annual meeting.

Other valuable prizes will be awarded winners during the tournament.

Play will be limited to afternoons during the convention, and both single and double matches will be arranged.

All doctors desiring to participate in the tournament should write or call a member of the tennis committee before the annual meeting. The committee is composed of Dr. S. L. Bivens, chairman, 308 Atlas Building, Charleston; Dr. Robert M. Biddle, 602½ Market Street, Parkersburg; and Dr. John E. Lutz, 603 Atlas Building, Charleston.

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COUNTY SOCIETIES

BARBOUR-RANDOLPH-TUCKER

Dr. O. Noel Morison, of Charleston, was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker Medical Society, held April 20, at the United Brethren Church, in Philippi.

The speaker discussed psychosomatic and psychiatric patients. He stated that doctors are inclined to overemphasize the psychosomatic, and that the psychiatrist must first be a physician and secondly a psychiatrist. He presented five cases, commenting on each case and pointing out the further study that will be required, and the treatment that will be necessary.—Donald R. Roberts, M. D., Secretary.

* * * *

CABELL

Dr. Carlo Scuderi, associate professor of orthopedic surgery at the University of Illinois College of Medicine, Chicago, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society, held April 13 in the Fireside Room at the Hotel Frederick, in Huntington.

Doctor Scuderi presented two very interesting films illustrating the technique and follow-up care and results in tendon transplants at the wrist joint for irreparable damage.

Dr. Robert P. Patterson, director of anesthesia at the Allegheny Hospital in Pittsburgh, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society held in the Fireside Room of the Hotel Frederick, May 11. His subject was, "Operating Room Emergencies."

The speaker presented an interesting paper and included a discussion on anesthesia explosions in the operating room, inadequate preparation of the patient for surgery, acute cardiac arrests, ether convulsion, incompatible blood transfusions, shock, and immediate postoperative reaction.

At the business meeting following the scientific program, Dr. Ross M. Dodson, of Huntington, was elected to honorary lifetime membership in the society.—James A. Heckman, M. D., Secretary.

CENTRAL WEST VIRGINIA

Dr. C. E. Watkins, of Oak Hill, president of the West Virginia State Medical Association, was the guest speaker at the regular meeting of the Central West Virginia Medical Society, held at the Community House in Sutton, May 18. Dr. Frank J. Holroyd, of Princeton, chairman of the state public relations committee, and Charles Lively, executive secretary of the State Medical Association, were also guests at the meeting.

Doctor Watkins discussed the proposed amendments to the constitution and by-laws, which will be considered at the annual meeting of the House of Dele-

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A. F. FORTUNE, M. D., MEDICAL DIRECTOR BEN F. FORTUNE, M. D., ASSOCIATE MEDICAL DIRECTOR

gates, at White Sulphur Springs, July 27-29. He asked the members of the society to make a thorough study of the proposals and urged that all members who can do so attend the annual meeting.

The speaker also discussed the work of the State Medical Association and the American Medical Association with reference to the threat of socialized medicine and emphasized the importance of continued activity to the end that the people may have a thorough understanding of the whole subject of socialized medicine.

At the business meeting following the scientific program, Dr. M. T. Morrison, of Sutton, and Dr. R. G. Cutright, of Buckhannon, were elected to honorary membership in the society.—Theresa O. Snaith, M. D., Secretary.

HANCOCK AND BROOKE

A joint dinner meeting of the Hancock County Medical Society and the Brooke County Medical Society was held at the Williams Country Club, in Weirton, May 11, 1950.

Short addresses were delivered by Mr. Thomas E. Millsop, of Weirton, member of the Board of Governors of West Virginia University; Dr. Charles E. Watkins, of Oak Hill, president of the West Virginia State Medical Association; Dr. E. J. Van Liere, dean of West Virginia University School of Medicine; and Mr. Charles Lively, executive secretary of the State Medical Association.

Mr. Millsop discussed the matter of the establishment of a four-year school of medicine and dentistry in West Virginia, stating most emphatically that the Board of Governors is interested in the development of such a school along with the necessary expansion of other existing schools of the University.

The speaker recalled that the matter of the advisability of the creation of such a school is being studied by Dr. Herman G. Weiskotten, dean of Syracuse University School of Medicine, and Dr. Wilburt C. Davison, dean of Duke University School of Medicine. This study is being made at the instance of the legislative interim committee set up at the 1949 session of the legislature. Mr. Millsop said that it is his understanding that the formal report from the deans of the two schools will be submitted within the next few weeks.

He suggested that a joint meeting of representatives of the Board of Governors, the School of Medicine, the Legislature, the State Medical Association, and the State Dental Society be held immediately upon the receipt of the report, and that Governor Okey L. Patteson be asked to sit in at the conference. Such a meeting, he indicated, would be advisable for many reasons, principally because of the importance of reaching a common agreement on procedure.

Mr. Millsop stated that all interested individuals and groups should make sure that funds are available for the construction and maintenance of the school before any step is taken with reference to obtaining an initial

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JOINT MEETING AT WEIRTON, MAY 11, 1950

Left to right, seated, E. J. Von Liere, M. D., Dean, West Virginia University School of Medicine; Joseph E. Hepp, M. D., Department of Gynecology, University of Pittsburgh School of Medicine; Alexander Brunschwig, M. D., Cornell University Medical College, New York City; and Charles E. Watkins, M. D., President, West Virginia State Medical Association. Standing, J. L. Thompson, M. D., Weirton; Charles Lively, Executive Secretary, State Medical Association; Leonard E. Yurko, M. D., President, Hancock County Medical Society; and Richard E. Flood, M. D., Secretary, Hancock County Medical Society.

appropriation from the legislature and the enactment of enabling legislation.

Doctor Van Liere discussed medical education at West Virginia University's two-year school of medicine, and recalled that several members of both the Hancock County Medical Society and the Brooke County Medical Society are graduates of that school.

Doctor Watkins spoke concerning the activities of the State Medical Association and asked that proposed changes in the constitution and by-laws be given study prior to the annual meeting at White Sulphur Springs, July 27-29.

The executive secretary, Charles Lively, presented an outline of the program that has been arranged for the annual meeting. He praised the members of the program committee for the thorough study that was made prior to extending invitations to speakers, and congratulated them for arranging a program that will appeal to both general practitioners and those engaged in the practice of a specialty.

Both Doctor Watkins and Mr. Lively urged that reservations be made promptly for rooms at the Greenbrier so that a definite idea may be had soon concerning the number of doctors and their wives who will attend the meeting.

Dr. Leonard E. Yurko, president of the Hancock Medical Society, presided at the dinner meeting, which was attended by more than 50 members of the Hancock Medical Society and the Brooke County Medical Society and visiting doctors from the Steubenville Academy of Medicine.

At the conclusion of the meeting in Weirton, the doctors present drove to Steubenville to attend a meeting of the Academy that evening at which Dr. Alexander Brunschwig, of Cornell University Medical College, New York City, was the guest speaker. His subject was, "Radical Surgical Treatment of Pelvic Malignancy."

The paper was discussed by Dr. Joseph E. Hepp, of the Department of Gynecology, University of Pittsburgh School of Medicine.—Richard E. Flood, M. D., Secretary.

* * * *

KANAWHA

Dr. Harvey E. Thorpe, of Pittsburgh, was the guest speaker at the regular monthly meeting of Kanawha Medical Society, held May 9, at the Daniel Boone Hotel, in Charleston. His subject was "Eye Conditions of Interest to the Internist and General Practitioner."

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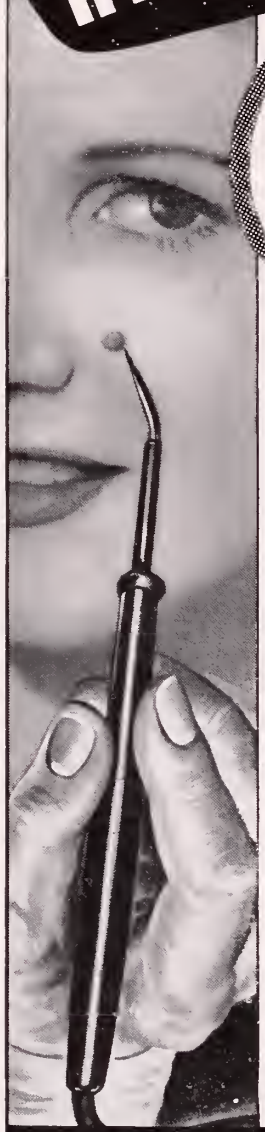

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At the business meeting following the scientific program, the following doctors were elected to membership in the Society: Richard C. Wallace, of St. Albans; John S. Blagg, of South Charleston; and H. W. Snodgrass, of Spencer.

Dr. E. F. Gott, of Charleston, and Dr. L. A. Jarrett, of Dunbar, were elected to honorary lifetime membership.—Robert C. Bock, M. D., Secretary.

* * * *

MERCER

Dr. D. V. Kechele, of Bluefield, was the guest speaker at the regular monthly dinner meeting of the Mercer County Medical Society, held April 17, at Pete's Grill, in Bluefield. He discussed "Breast Cancer" and presented a review of the literature on the subject.

The following diabetes committee was appointed by the president: Drs. O. G. King, Karl E. Weier, and Daniel Hale.—Frank J. Holroyd, M. D., Secretary.

The Red Cross Blood Bank program was discussed at great length at the regular monthly meeting of the Mercer County Medical Society, held May 15, at Pete's Grill, in Bluefield.

The secretary was instructed to write the local units of the Red Cross to the effect that the society feels the present blood bank program of the hospitals in Mercer county is adequate, but that if the Red Cross desires to sponsor a blood bank program, the Society will cooperate in every way possible.

The rise and fall of the city-county health unit was discussed by Dr. Frank J. Holroyd.

The Lilly sound picture, "The Kidney in Health," was shown by Dr. Charles M. Scott.

At the business meeting, Dr. H. E. Troup, of Bluefield, was elected a member of the Society, and Dr. Jess P. Campion, of Princeton, was accepted as a member by transfer from the McDowell County Medical Society.—Frank J. Holroyd, M. D., Secretary.

* * * *

MINGO

Dr. Frank J. Holroyd, of Princeton, chairman of the state public relations committee, was the guest speaker at the regular monthly dinner meeting of the Mingo County Medical Society, held in the auditorium of the Appalachian Electric Power Company, at Williamson. He discussed the importance of obtaining the adoption of resolutions by local groups and presented an interesting discussion of medical public relations.

The Wyeth Company's sound film on "Allergy" was shown following Doctor Holroyd's address.

Dinner was served under the auspices of the Woman's Auxiliary to the Mingo County Medical Society.—E. T. Drake, M. D., Secretary.

* * * *

MONONGALIA

At a meeting of the Monongalia County Medical Society, held May 2, at Morgantown, the following resolution was adopted:

WHEREAS, there now exists a demand for services of practical nurses, which demand may be expected to increase, particularly in connection with the home care of chronically ill patients; and,

WHEREAS, at the present time anyone who so desires may set herself up as a practical nurse, without

regard to training, experience or qualifications, either concerning professional capacity or even her own health; and,

WHEREAS, since the members of the medical profession are primarily concerned with the quality of the care provided for their patients, it becomes our duty to inquire into the aforementioned qualifications:

NOW, THEREFORE, BE IT RESOLVED, That the Monongalia County Medical Society favors the establishment of some agency at state level to determine standards and to promulgate and enforce regulations looking toward the provision of the best possible quality of practical nursing care for such of our patients as may require such care; and,

BE IT FURTHER RESOLVED, That the Committee on Legislation of the West Virginia State Medical Association be requested and urged to initiate the necessary steps toward this end, working in conjunction with the State Nurses Association, the State Health Department and others interested; and,

BE IT FURTHER RESOLVED, That a copy hereof be transmitted to the Executive Secretary of the West Virginia State Medical Association, to the Secretary of the State Nurses Association, and to the Chairman of the aforementioned Legislative Committee.—Maynard P. Pride, M. D., Secretary.

* * * *

OHIO

Dr. R. U. Drinkard, Jr., of Wheeling, was the guest speaker at the regular monthly meeting of the Ohio County Medical Society, held May 2, at Wheeling. He gave the annual Schwinn Memorial lecture and his subject was "Coronary Insufficiency."

At the business meeting following the scientific program, Dr. W. Carroll Boggs was elected president for the ensuing year. The other new officers are Dr. John H. Murphy, vice president, Dr. R. Alan Fawcett, Secretary, and Dr. A. J. Niehaus, treasurer (reelected).

The following delegates and alternates to the annual meeting of the State Medical Association at White Sulphur Springs, July 27-29, were named: Delegates, Drs. D. E. Greeneltch, Robert J. Reed, Jr., George L. Vieweg, Wm. M. Sheppe, and W. Carroll Boggs. Alternates, Drs. R. U. Drinkard, John H. Murphy, A. J. Niehaus, James D. Bird, and Francis J. Gaydosh.

The following doctors were elected to membership in the society: Dr. Howard T. Phillips, Jr., Dr. Raymond J. Duffy (by transfer from the Massachusetts Medical Society), Dr. George R. Clark (by transfer from the Milwaukee (Wisconsin) County Medical Society), and Dr. Robert W. Leibold (by transfer from the Green County (Pa.) Medical Society).—W. Carroll Boggs, M. D., Secretary.

WYOMING

At the regular April meeting of the Wyoming County Medical Society, held at the Wyoming Hotel, in Mullens, Linde Air Products presented a sound film illustrating oxygen therapy and demonstrating the use of portable equipment for emergency oxygen therapy.

Dr. R. C. Hatfield was elected president for the ensuing year, and Dr. J. F. Biggart was reelected secretary-treasurer.—J. F. Biggart, M. D., Secretary.

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Personal Course in General Surgery, Two Weeks, starting September 25.
Surgery of Colon & Rectum, One Week, starting September 11.
Esophageal Surgery, One Week, starting October 16.
Breast & Thyroid Surgery, One Week, starting June 26, October 2.
Thoracic Surgery, One Week, starting June 12, October 9.
Gallbladder Surgery, Ten Hours, starting June 19, October 23.
Fractures & Traumatic Surgery, Two Weeks, starting June 12, October 9.
Basic Principles in General Surgery, Two Weeks, starting September 11.

GYNECOLOGY—Intensive Course, Two Weeks, starting June 19, September 25.
Vaginal Approach to Pelvic Surgery, One Week, starting September 18.

OBSTETRICS—Intensive Course, Two Weeks, starting September 11.

MEDICINE—Intensive General Course, Two Weeks, starting October 2.
Electrocardiography & Heart Disease, Two Weeks, starting July 17.
Gastroscopy, Two Weeks, starting July 17, September 25.

DERMATOLOGY—Formal Course, Two Weeks, starting October 16.
Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting September 25.
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WOMAN'S AUXILIARY

KANAWHA

Mrs. Pat A. Tuckwiller, of Charleston, was installed as president of the Woman's Auxiliary to Kanawha Medical Society at a "nosebag luncheon" held May 16 at the home of Dr. and Mrs. W. F. Shirkey on Indian Creek Road, near Charleston. Other officers were installed as follows: President elect, Mrs. Charles Staats; first vice president, Mrs. Duke Dent; second vice president, Mrs. W. P. Elkin; third vice president, Mrs. Newman Newhouse; corresponding secretary, Mrs. John Condry; recording secretary, Mrs. A. B. C. Ellison; and treasurer, Mrs. A. B. Bowyer.

All officers were installed by Mrs. A. C. Chandler, of Charleston, past president of the Woman's Auxiliary to Kanawha Medical Society.

Delegates and alternates were named for the 26th annual meeting of the Woman's Auxiliary to the West Virginia State Medical Association at White Sulphur Springs, July 27-29.

Chairmen of standing committees were appointed by the president as follows: Public relations, Mrs. Joel Allen; legislative, Mrs. W. E. Hoffman; Today's Health, Mrs. J. A. B. Holt; exhibits, Mrs. George Miyakawa; parliamentarian, Mrs. Ralph Jones; visiting, Mrs. R. H. Vial; auditing, Mrs. J. E. Rucker; speakers bureau, Mrs. V. L. Peterson; historian, Mrs. W. A. Thornhill, Jr.; Bulletin, Mrs. Pearl Peck; finance, Mrs. Hunter Boggs; special projects, Mrs. J. N. Reeves; nurse recruitment, Mrs. Edwin Shepherd and Mrs. W. B. Rossman; and cancer closet, Mrs. Randolph Anderson and Mrs. J. E. Grace.

Hostesses for the meeting were Mrs. R. K. Buford, chairman, and Mesdames R. H. Walker, John T. Jarrett, George F. Grisinger, Jr., Philip Preiser, E. B. Henson, G. C. Irwin, J. N. Reeves, R. H. Dunn, William Rice, Harry Baldock, Francis Clark, and O. B. Bobbitt.—Mrs. V. L. Peterson, Corresponding Secretary.

* * * *

MERCER

Mrs. Paul C. Craig, of Reading, Pennsylvania, was the guest speaker at the luncheon meeting of the Woman's Auxiliary to the Mercer County Medical Society, held April 10, at Pete's Grill, in Bluefield. Her subject was, "Quest for Health."

The speaker discussed the progress made in medical care during the past 50 years, declaring that this period was "man's greatest half-century." During this period, life expectancy has been increased by 20 years. She discussed the provisions of Senate bill 1679, and stressed the fact that a heavy increase in taxes would be necessary if the bill is enacted into law.

Mrs. Frank J. Holroyd, of Princeton, president of the Auxiliary, presided at the luncheon, which was attended by 57 members and guests.—Mrs. F. S. Richmond, secretary.

RALEIGH

The regular monthly meeting of the Woman's Auxiliary to the Raleigh County Medical Society was held April 17, at the Beckley Hotel, in Beckley, with 21 members present.

The guest speaker, Dr. Frank J. Holroyd, of Princeton, was introduced by Dr. C. A. Smith, president of the Raleigh County Medical Society. Doctor Holroyd spoke most interestingly on the subject of "How Socialized Medicine will Affect the Doctors."

At the business meeting, a resolution opposing compulsory health insurance was adopted unanimously.

Donations were ordered made to the March of Dimes, the Red Cross, and the Jane Todd Memorial Fund.

The following officers were elected for the new year: president, Mrs. R. G. Broaddus; president elect, Mrs. D. C. Ashton; vice president, Mrs. W. C. Mays; secretary, Mrs. G. H. Fordham; and treasurer, Mrs. W. B. Lilly.

Mrs. C. A. Smith, Mrs. W. C. Covey, and Mrs. W. C. Patterson were elected delegates to the annual meeting at White Sulphur Springs, and Mrs. Sam Sato, Mrs. W. H. Rardin, and Mrs. Fred Richmond, alternates.—Mrs. L. M. Halloran, Secretary.

CORRESPONDENCE

STATE DEPARTMENT OF PUBLIC ASSISTANCE
Charleston, W. Va.

April 27, 1950

Mr. Chas. Lively, Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia

Dear Mr. Lively:

On Tuesday, April 25, 1950 there was held in the administrative offices of the State Department of Public Assistance, at No. 2 Morris Street, Charleston, West Virginia, a joint meeting of representatives of the State Hospital Association and the State Medical Association with officials of the Department of Public Assistance. The purpose of this letter is to verbally confirm that which was released at the meeting, specifically, that the Department of Public Assistance has exhausted its appropriation for general medical and hospitalization for needy clients for the fiscal year 1949-50. Considerable discussion was had during the conference and an attempt will be made in the near future to work out plans for the care of needy indigent persons during the year 1950-51.

In the meantime, it has become necessary that the General Medical and Hospitalization Program of the

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Charleston 5, West Virginia

Department of Public Assistance be closed effective midnight, April 30, 1950, at which time any funds of the Department available for servicing new cases will be completely exhausted. During the month of May and the month of June no new cases will be accepted by the Department for payment and no authorizations dated after April 30, 1950 will be honored either by individuals or offices of the Department at any point in the state of West Virginia.

We deeply regret that this action has become necessary but there seems no other course open which may be successfully followed to the advantage of all concerned.

It is definitely true that an appropriation made for the next fiscal year could not be invaded to pay bills incurred during the present fiscal year and there would be little point in so doing if it were legally possible since to do so would deplete to a greater extent funds which will become available to the Department as of July 1, 1950. Payment to doctors and hospitals will be resumed on July 1, 1950 and authorizations will be issued for services given on and after July 1, 1950 to eligible clients of the Department. No bills incurred during the months of May and June will be paid out of July monies and it is only fair that each and every doctor in West Virginia be made aware of this situation.

The General Medical and Hospitalization Program has for some years created an ever increasingly difficult problem. Expenditures in behalf of that program even during the past nine months have increased alarmingly. For instance, in the month of July, 1949 medical payments (payments to doctors) amounted to $25,386.26. During the month of November, 1949 a small increase had been noted and payments amounted to $28,406.07. In January, 1950 payments were made for medical services in amount of $35,415.83, while in the month of April, 1950 payments for medical services will amount to $40,314.83. At the same time, payments to hospitals increased in the following manner:

July, 1949	$29,966.16
November, 1949	55,250.66
January, 1950	69,493.97
April, 1950	77,910.48

Thus it may be seen that with the ever increasing expenditures and the non-availability of funds, the Department has no choice but to close this program. Authorizations which have been issued prior to April 30, 1950 at midnight will be honored and a sufficient amount of money will be available to take care of cases which are in the process of treatment. No new cases will be accepted.

With deep regret that this letter becomes necessary, I am

Very sincerely yours,

Robert F. Roth, Director.

RFR:c

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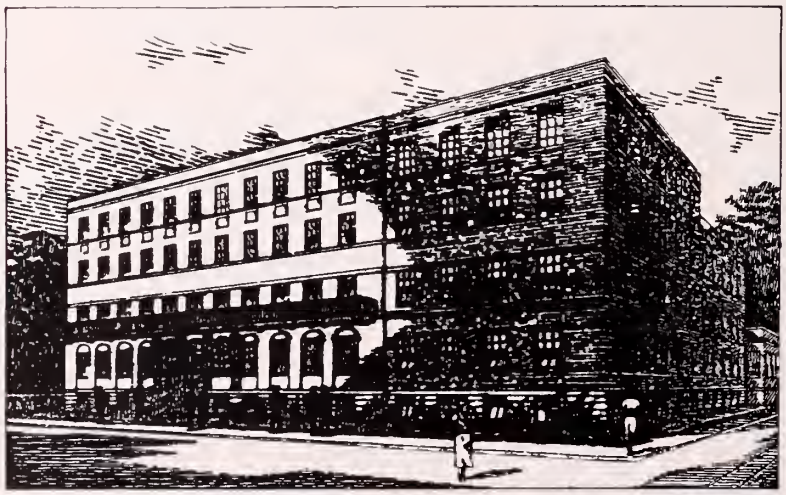

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BOOK REVIEWS

A MANUAL OF CARDIOLOGY—By Thomas J. Dry, M. A., M. B., Ch. B., M. S. in Medicine, Associate Professor of Medicine, University of Minnesota (Mayo Foundation). New, Second Edition. Pp. 355, with 97 figures. Philadelphia and London: W. B. Saunders Co. 1950. Price $5.00.

This small volume, claiming only to be a manual, deserves wide circulation and use, for it carries a world of information, clearly written, concise and up to date. Especially of interest to this reviewer are the descriptions of the use and meaning of precordial leads in various cardiac conditions, descriptions which are stripped of the technical and theoretical details which are so confusing, and which make unreadable and valueless for ordinary mortals most of the material one finds in books and journals on this subject.

The clarity with which the whole book is written, covering as it does, though briefly, the whole field of heart disease, should make this a popular book of use to students and practitioners alike.—Frederick R. Whittlesey, M. D.

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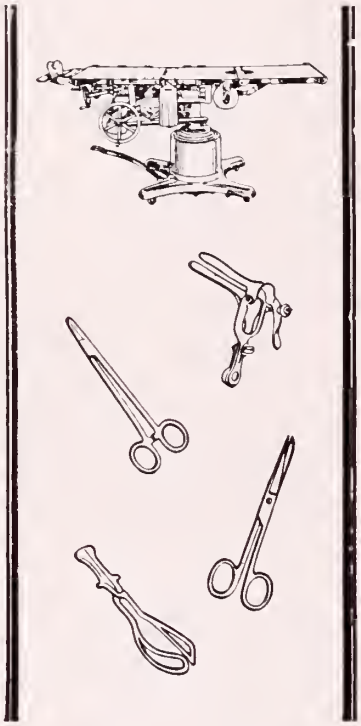

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Editor
WALTER E. VEST, M. D.
955 Fourth Ave.
Huntington, W. Va.

Managing Editor and
Business Manager
MR. CHARLES LIVELY
Box 1031
Charleston 24, W. Va.

Associate Editors:
EDWARD J. VAN LIERE, M. D.
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PROGRESS AND PROBLEMS IN NATIONAL HEALTH*

By LEONARD A. SCHEELE, M. D.,
Surgeon General, Public Health Service
Federal Security Agency
Washington, D. C.

Everyone here tonight can carry home the realization that he has taken part in a significant event. Here, a state university and its medical school, with the health department cooperating, have taken the leadership in sponsoring a conference on public health. The purpose is to explore current national problems in that field as they relate to West Virginia with a view to solving those problems so that the people of this state may enjoy better health.

This is a progressive move on the part of West Virginia University and the School of Medicine. The partnership between education and public health which this conference symbolizes is based upon mutual interests and mutual objectives. The aim of the university is to train youth not only in special fields of service and for earning a livelihood, but also in the art of living and of being good citizens in our democracy. Its aim also is to contribute to the body of knowledge and to the solution of technical and social problems. Public health and medicine, in turn, depend upon the university for recruits, for continued training of personnel and for enlightened citizens who will participate in the solution of health problems.

Many of the problems which bring us together here in Morgantown are national in extent. Health and medical personnel are in short supply in some parts of every state in the Union. In some instances, the shortages are statewide. Four states besides West Virginia have only a two year medical school and eleven have no medical schools at all.† I do not mean to imply that every state should have a medical school. On the other hand, all of us realize that students from states having no schools frequently have difficulty gaining entrance to schools in other states, especially those in state universities. The need for hospital beds and health facilities, especially for general hospitals and health centers, also is nationwide, with marked variations in the degree of deficiency. Not a single state has adequate coverage with full time local health services. Staffing of existing local health units is inadequate in all but a very few areas.

I mention these broad problems because it is no secret to you that West Virginia is low in the scale of availability of personnel, training, facilities and organization of services. What I want to stress is that your very needs and lack of previous development vastly increase your opportunities to develop new programs.

We are on the threshold of a new era in medicine and public health. New hormonal substances such as cortisone and ACTH, for instance, are likely to change our approach to many killing and disabling illnesses. Their use is likely to raise critical problems in health economics which must be solved if these and other effective agents are to be more than "rich men's" drugs. The technics, equipment and therapeutic agents which we possess today are the gifts of scientific

*Presented before the Conference on Public Health sponsored by West Virginia University School of Medicine, Morgantown, March 31, 1950.

†Mississippi, New Hampshire, North Dakota, South Dakota, and West Virginia have only a two-year medical school. Arizona, Delaware, Florida, Idaho, Maine, Montana, Nevada, New Jersey, New Mexico, Rhode Island and Wyoming have no medical school.

research, that is to say, the gifts of creative planning, creative thought and action in the laboratory, the research hospital and the field study. If these gifts are to be used widely for the health of the people, our physicians, nurses, health engineers and all other professions involved in the provision of services will have to join with other citizens in planning and action no less creative and experimental than that of the research scientist.

I note that in these two days of conference you will discuss a number of specific problems interesting to all of us. You have assembled a roster of experts from West Virginia, from neighboring states and from distant institutions. I shall leave the technical aspects of health programs to your speakers and able discussants. I want instead to explore a little farther some of the basic problems I have mentioned. These include training and research, personnel and facilities, and organization of services.

I would not have you think that these problems should be taken up and solved separately and in the order I have mentioned. Each is closely related to all of the others. In West Virginia, as elsewhere, men and women concerned for the people's health must direct their efforts against all of these deficiencies at the same time. Progress in one sector may be more rapid than in another, but the effort must be united.

There is encouraging evidence that your efforts in West Virginia are beginning to get results. We in the Public Health Service have been following with great interest the action of your state legislature in the past year. The new law which makes it possible for counties and cities to join more effectively in the provision of local health services has not been overlooked. West Virginia's state appropriations for public health increased by 125 per cent in the single year from 1949 to 1950. The provision of 43 cents per capita for the state health department's 1950 budget represents notable progress, although it is well below the national average of 58 cents per capita, and far from its high of $1.61. Proportionately, West Virginia's increase in state appropriations for public health was greater than that of any other state.

A MEDICAL CENTER FOR THE STATE

I am not unmindful of the many calls upon state and local revenues. The delays in establishing a four year medical school at West Virginia University, for example, are undoubtedly attributable in large part to the high cost of such a program in relation to the University's total needs. We in public health work do not disregard the fact that medical education and research cannot function without the total background of the liberal arts and sciences. Moreover, we realize that lawyers and teachers, sociologists and poets, historians and business administrators, are just as important to our Nation as are scientists and physicians.

The fact that people of all political faiths in West Virginia have agreed on the need for a medical center in this state gives encouragement to all who would foster the advance of medicine and public health. The solution of many other problems will come about quicker and more easily once your plans for a medical center materialize.

I would hope, for example, that the affiliation of medical education and public health, already evidenced in this conference, will be ever closer and will extend to other activities. Future progress in public health will depend more and more upon the knowledge and skill of the individual physician, especially the general practitioner. His training in preventive medicine and the social aspects of health and sickness will be the foundation upon which is built cooperation between the local health service and the local medical profession. The programs of the state and local health departments, in turn, offer many opportunities for the training of physicians and other essential personnel.

The university medical school has another vital function, that of research in the medical and related sciences. An important objective of the research grants and fellowships program of the Public Health Service is to build up the research strength of areas that are at present undeveloped. This is a slow process but its development has great promise for the advance of science and human health in future years. The capacity of an area to conduct research depends upon the availability of qualified scientists and research facilities. The lack of a four-year medical school and adequate research facilities in West Virginia is reflected by the fact that in 1949 only one of more than a thousand Public Health Service research grants was made in this state.

A medical school, as well as a research program, must have enough clinical material readily available. The selection of a site for a medical center, therefore, may become a knotty problem in states in which the distribution of population is uneven. There is also the human factor. I am sure, nevertheless, that these problems can be solved. The requirement is that all those concerned keep their eyes on the mutual objective: "What do we want to achieve?" Yes, some individuals, some organizations, may have to sacri-

fice a little more of their independence than others in the location of medical schools. When a school is wisely located the ultimate gain for all is greater than the individual sacrifices.

HOSPITALS AND HEALTH FACILITIES

As the states come nearer to their goal of adequate hospital and health facilities, one can visualize also a university medical school as the base of a coordinated hospital system, affiliated with public health services. In West Virginia such a medical center could develop programs of training, research and service that would raise the level of medical and hospital practice and public health administration throughout the state.

The National Hospital Survey and Construction Program administered by the Public Health Service, as you know, is aiding in the construction of facilities throughout the country, according to regional plans worked out by the states. The intent of Congress was that federal aid should be directed primarily to the provision of general hospitals in areas in which they are most needed. This objective was also recommended by hospital and health authorities and civic groups. It was expected that state planning and state administration would give more than lip service to meeting those priorities. The national figures show that most of the states are keeping faith. This prime objective of the program, to place hospitals where patients and doctors need them most, is being achieved.

As of January 1, 1950, more than 1,000 projects providing 50,000 beds had been approved for federal construction grants. Fifty of the projects had been completed, and 450 others were under construction. Seventy per cent of the 50,000 beds will be in general hospitals. Three-fourths of the new general hospitals are to be located in small towns and villages and will have less than 50 beds each.

It is disappointing, to say the least, that West Virginia has been slow in developing hospital and health facilities for her areas of greatest need. As of January 1, 1950, application had been made for grants to aid in the construction of only nine hospitals. Of these, only three are general hospitals and not one of the three is located in a rural or isolated region. These hospitals will provide only 218 beds to meet the state's estimated need for 5,000 general beds.

In contrast, consider the construction program of Mississippi, a state with the lowest per capita income in the Union, a state of small cities and towns and rural areas. As of January 1, 1950, Mississippi had received approval of construction grants for 83 projects. All of the projects are for small general hospitals in small communities. Nine have been completed, and 32 are under construction. The remaining 42 are already in the blueprint stage. Many of these new community hospitals will include health centers for Mississippi's rapidly developing local health departments.

Or, consider Ohio, your neighbor state to the west. A combined hospital and health center has already been completed at Wooster, a small town, and ten others have been approved for construction grants.

The national picture of hospital construction with many small hospitals rising on the soil of rural and isolated communities, highlights the importance of regional medical centers. Small hospitals and small communities especially need the consultant services and facilities of a medical center which conducts a strong program of training and research.

ORGANIZATION OF SERVICES

I am sure that many of you here tonight would cite local health organization as an urgent need in West Virginia. The new law which I mentioned earlier is evidence of your interest in this problem. The situation here certainly leaves no doubt in our minds that the need is critical. As of January 1, 1950, there were 29 single-county and district local health units, mostly on paper. Of 20 single-county units, for example, only seven had a health officer. Nine local health districts were planned to serve 28 counties, but four of these were still without health officers. The twelve single-county and district units with health officers serve a little less than half the population. No unit in the state was staffed well enough to meet the minimum standards established by the American Public Health Association.

Now what is the situation for the country as a whole? As of June 30, 1949, there were 1,291 full time local health units serving 1,648 counties and 273 separate cities. These figures represent a great improvement over 1936 when there were only 556 local health units serving 751 counties. Many of the present day health departments are combined units, or local health districts, serving two or more counties. In 1949, only 57 counties in the entire country had local health services well enough staffed to meet the minimum standard. We are still far from nationwide organization, with enough public health workers to make the existing local services effective.

These figures should be sufficient evidence of need. I would remind you further that the modern concept of public health administration is based squarely upon decentralization of services. A generation or two ago, it was possible for a relatively small staff in the state health agency to conduct the few programs and apply the few available procedures for the control of epidemics. That day has gone forever.

State staffs conducting industrial hygiene and environmental health activities, for example, no longer can apply the broad new concepts and the many new procedures effectively without those indispensable outposts, the local health units. The same is true of our efforts to apply modern methods of case-finding and treatment to the control of tuberculosis, venereal diseases, cancer, heart disease and a host of other disabling conditions. This conference has recognized the importance of public health work in these special fields of industrial health, mental health, environmental sanitation and chronic disease control. I trust that you will keep in mind the cold fact that without local organization of services, the most brilliantly devised technics will receive little practical application.

The Public Health Service, together with the American Public Health Association, the American Medical Association, other professional organizations, the National Congress of Parents and Teachers and many civic groups, has supported legislation before Congress which would augment federal aid for local health units. This bill passed the Senate and is before committee in the House of Representatives.

I shall be candid. There is some likelihood that we will not have increased federal appropriations for local health in the next fiscal year, either through the regular budget of the Public Health Service or through the proposed local health units bill.

The source of this defeat, if it comes, would lie, I believe, in the states and localities themselves. Public demand for increased support of local health units has been lukewarm, by comparison with the strongly organized efforts of voluntary groups seeking increased federal aid in solving specific health problems such as cancer, heart disease and mental disease. Personally, I cannot believe that there is anything inherently more dramatic or appealing than the daily service of local health workers to the people of their communities. I submit that state and local health departments, in many instances, have not made that service sufficiently swift, direct and humane. They have not shifted their programs to meet the major health problems which confront the American family today. Lukewarm service will get lukewarm support.

The local health department should be the key agency in each community to bring together voluntarily in harmonious working relationship all organized services that contribute to the health of the people. In West Virginia, as elsewhere, there are scores of organized programs that have an impact upon individual health. Official and voluntary agencies provide the services. National, state and local agencies are involved. Hospitals and visiting nurse societies, welfare and voluntary health agencies, prepayment plans and industries, no less than public health agencies, all provide some type of organized health service.

The family in need of service wanders through the maze, often without receiving the care required for its specific problem. Let me say here and now that the family in need of organized health services is by no means invariably a family "on relief" or a low income family. The industrialized society in which all of us live demands organized service of one kind or another for all.

The Division of Tuberculosis in the Public Health Service is at present conducting some very interesting follow-up studies of community case-finding surveys made in large cities. I am sure that Doctor Robert Anderson, chief of the Division, who will be on the program tomorrow, could tell you some interesting facts about the number of health and welfare agencies involved in the provision of services for the tuberculosis patient and his family. A recent study completed in Philadelphia points again to the urgent need for the integration of health and welfare services. Thus, we see amply demonstrated the need for focusing these many separate services into better coordinated community programs.

PUBLIC HEALTH PERSONNEL

If local health departments are to be increased in number, strengthened in services, and endowed with new responsibilities, the problem of staffing becomes paramount. In your state, Doctor Dyer's difficulties in recruiting qualified personnel have been well-nigh overwhelming. Both the regional and headquarters staffs of the Public Health Service are helping him in every way possible. We all hope that the nationwide recruitment program of the American Public Health Association will help bring more trained people into public health.

We are all aware that the salaries of public health personnel can be either an incentive or a deterrent to recruitment. West Virginia has

raised the ceiling on health officer salaries. Most of the other states have done the same. But many essential groups, such as public health nurses, are still grossly underpaid. We have a long way to go before all states recognize that the men and women responsible for the health of thousands of people should be adequately compensated and properly esteemed for that duty.

TEAMWORK

The concept of decentralization of services implies the friendliest collaboration among local health agencies, local medical societies, and their counterparts at the state and national levels. Teamwork is one of the incentives in public health work that offsets, in part, inadequate compensation. We in the Public Health Service have long operated on the basis that the state and its health officers are autonomous within their jurisdiction. Our role has been that of partner, consultant and source of technical and financial aid. In our experience, the local health department will develop effective programs and win public and professional support when, and only when, it enjoys the same relationship with its state health agency.

Once a community or a district has taken the important step of setting up a local health service, the health officer and his staff should be given full responsibility for the program within their area. Free and frequent contact with state and local agencies and institutions is also an incentive to well qualified personnel. Without complete support of the public, the professions and the state health department staff, the local staff loses stature, and its efficiency is weakened. In short, in planning for the extension of local health services we must do more than give lip service to the ideal.

CITIZENS' PLANNING

In our democracy, the states and their communities can go as far as they wish toward the provision of health services, including provisions for medical care. When we say "states and communities", we mean the people, the men and women who have family problems, personal and community problems, on their minds. As West Virginians develop their state health planning committee, I am sure that the goals defined by the health professions, and many other goals, perhaps, will be adopted by the public. Moreover, if they are given an opportunity to participate in the study of health problems, in planning and action for public health, citizens will have much to contribute to the perspective and thinking of the professions. They are absolutely essential supporters when recommendations are to be implemented.

The broader the representation on such health councils, the surer and the stronger will be public support. Many agencies need to recognize this fundamental truth. Not the professions and the leading members of society alone have an interest in public health, not they alone have a contribution to make. Here in West Virginia, for example, the understanding and support of organized labor, the mine workers, the steel workers, of the small farmers and of the general public are essential to public health progress, as well as to progress in education of the health professions. After all it is for them that the services are organized. They are the consumers.

Here in West Virginia you have lived close to disaster through the long history of mining and other hazardous occupations. You have had to face the realities of catastrophic injury and sickness. As a result, the percentage of population enrolled in prepayment plans for hospital and medical care is higher in West Virginia than it is in any other state, with the possible exceptions of Washington and Oregon. This phenomenon is due, of course, to the coal mine plans originating back in the nineteenth century. The metamorphosis from the old contract-doctor service into the present day union health and welfare program, assuring comprehensive health and medical services to miners and their families, places West Virginia in a strategic position. You can go forward to the development of a state health program that might well be a guide to other states in the provision of comprehensive care.

Surely it is a goal of public health and medicine to help solve the health problems of all groups. With the kind of cooperation among the professions and the public which this conference symbolizes, I am sure we shall attain that goal in the near future.

THE FAMILY PHYSICIAN

Medical progress and social change have radically altered the qualifications of the Family Physician. Some practical psychology, a beard, a bottle of calomel, and a little medical knowledge are no longer sufficient professional equipment, and today's general practitioner is a skilled and well educated scientist, permitted and expected to practice modern medicine and surgery to the limits of his ability and experience.

But the need for sympathetic medical contact with the family unit is greater than ever before, even though more difficult of accomplishment. And there are few, if any, areas of medical practice today which offer more opportunity for human service or greater spiritual rewards for the doctor himself.—W. E. Barstow, M. D., in J. Michigan St. Med. Soc.

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MILESTONES IN PUBLIC HEALTH*

By THOMAS PARRAN, M. D.,
Pittsburgh, Pa.

As Sigerist and other great medical historians have made abundantly clear, one may devote a lifetime of study to the milestones of the past and still fail to exhaust their possibilities for interpretation to the pioneers of the present. In order to simplify this problem, I had decided to limit my considerations arbitrarily to the century immediately behind us. Yet it is difficult to exclude the 19th century as a whole.

"In its first half (in Great Britain, to quote Williams in 1929†) may be found the key to the understanding of many of our modern social situations. To that period belong the old Poor Law and its offshoot, Public Health—a vigorous child which in our own day has superceded its discredited parent. As the years go on, they diverge . . .", although as late as 1876 proposals were made to fuse them into a single system. It is even more difficult to exclude some aspects of preceding centuries. It is, of course, impossible to discuss the milestones in our own country alone.

The Poor Laws are rooted in the time of Henry VIII. When this ruggedly individualistic king of England dissolved the monasteries and confiscated their revenues, he precipitated as great a transformation in the social order of his country as in its theological practices. For the monasteries had maintained a vast system of social relief, including hospitals and asylums as well as apportionment of alms for the vagrant poor. Not until 1601 in the later part of Elizabeth's long reign, in order to deal with the situation developed by her father's drastic action, were the Poor Laws enacted. Under their provisions, property was assessed for the relief of the poor; "overseers" were appointed to provide the poor with work, to apprentice their children and to build houses for the reception of the sick.

In 1772 workhouses were established. Paupers who refused to live in them were not entitled to other relief. Only in 1795 was a food allowance, based on the price of bread, permitted for the pauper in his home.

Three years later Malthus published his first essay, "On the Principle of Population as It Affects the Future Improvement of Society." His well known thesis was that population was likely to increase in geometric ratio, in spite of checks by war, famine and epidemics, while the increase in food supply would not exceed an arithmetical ratio. There is more than a faintly familiar sound to his condemnation of the Poor Law doles as an incentive to large families, and his urging of "moral restraint and late marriages" as a means of averting such disaster.

It is reported that Charles Darwin in reading Malthus was struck by the phrase "struggle for existence" and stimulated thereby to find the key to biologic change in the process of natural selection.

The first hint of prevention as a social philosophy came in 1838 when Edwin Chadwick persuaded the Poor Law Commissioners that it would be "an economy to prevent evils ascribable to physical causes." Yet the Commissioners were unable to secure acceptance of their recommendations of 1844-45 for laws to secure drainage, sewerage and water supply through additional powers to be granted to the Crown and to local authorities. Then, as now, prejudices, taboos and vested interests were factors in the delay of reform.

The term "public health" was first used in 1848 by the Act of Parliament establishing the General Board of Health. It was short lived, as was our own National Board of Health 30 years later, being abolished except in name after six years. In fact, Chadwick himself was separated from public service in 1858 although three decades later he received warm if belated recognition and a KCB for his pioneer efforts.

This may or may not be comforting to some of you present day pioneers. Fame can not be the spur. Reward may be sure but unless you attain to a Chadwick's longevity it may be posthumous. In the same year that Chadwick was put out of office, the embryonic science of preventive medicine which he had fathered was committed to the direction of the Privy Council in the affairs of which, one may be sure, it did not have a very prominent position. Six years later, however, spurred by a serious epidemic of cholera, a Sanitary Enactment made it the duty of local officials to arrange for inspections and to suppress nuisances. This authority was defined to include "overcrowding in houses" and to involve the power "to institute a water supply."

In 1861, Florence Nightingale, fresh from her successes in the Crimean War, introduced the first nurses into Brownlow Hill, a Poor Law hospital of Liverpool. Six years later she played a substantial part in the creation of the London Metropolitan Asylums Board, soon to develop the largest hospital system in the world.

A government commission of 1871 recommended that each local jurisdiction should appoint an official of approved qualifications

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†"A Century of Public Health in Great Britain"—H. Williams, 1929.

combining in one person the functions of medical officer of health and of the medical officer of the Poor Law district and, in the language of the commission report, thus "uniting preventive and curative treatment under one head." On the contrary, the Public Health Act of 1872 established a complete system of health authorities all over the country independent of the Poor Law. In 1888 the Local Government Act required that such authorities be administered by physicians who had qualified for a diploma in public health and sanitation.

Criticism of the dual administrations continued, however. Beatrice Webb restated the case in 1910 saying, "It is not even the business of the medical officer for the poor to reduce sickness in his district . . . (but only to) . . . relieve destitution; that is, to supply medical relief. From first to last there is no conception of the public health point of view."

Because of the great increase in unemployment which strained the system to the breaking point, the Poor Law was finally abolished following the minority report of the Royal Commission of 1909. The Health Insurance Act initiated by its Liberal Party under the insistance of David Lloyd George in 1912 spread the cost of illness for wage earners, one-third of the total population. It has since been strengthened and expanded by Conservative, Liberal, coalition and Labour Governments to the point of which you are well aware and which causes more concern in the breasts of organized medicine in this country than does the spread of Communism to a senator from Wisconsin. One point should be recalled, however. The Current National Health Service Act in Great Britain was sponsored by the wartime coalition government directed by Winston Churchill. Now, as the leader of the minority party, he has not attacked the basic provisions of the Act.

Even though any student of the subject will point out vast gaps in my summary. I have dwelt at perhaps burdensome length on the British pioneer experience in dealing with health and the closely related welfare problems and have mentioned, only in passing, their current travail. I have done this for two reasons: (1) because our institutions and our philosophy of government are so concretely based upon the British system of common law rather than that of any other country of origin of our racially heterogeneous population and (2) because I feel safe in assuming that so literate an audience as this is familiar with the significant early milestones of public health in America.

You will remember Lemuel Shattuck as our first great pioneer, best known for the report of the Massachusetts Sanitary Commission (100 years ago) which has had great influence on the development of public health. Again we see the time lag between plan and implementation. It required 19 years for the creation of a state health department in Massachusetts along the lines suggested by Shattuck. In addition, he was the prime mover in his native state in the passage of the first law requiring central registration of births, deaths and marriages.

It has been said that advances in the development of public health as an organized community effort, supported by public funds, paralleled the astounding advances of the past century in the medical and other biologic sciences. As a matter of fact, and every public health officer in this audience will bear me out, application of medical science for the benefit of the general population has trailed the discovery by many years. Let alone moving forward as a team, these two good horses are not even hitched tandem. I think Surgeon General Scheele and Doctor Dyer would agree that shortening the leg between the proof of new and useful medical knowledge and its application in public health practice is the centuries-old core of our contemporary public health problems.

Nevertheless, without the milestones of medical and bacteriologic science public health would have had no fulcrum. Translated from scientific to political terms, it is fair to say that Pasteur's demonstration of the role of bacteria in causing disease marked the beginning of a revolution. Fuel was added to the flame by Koch's improvement of bacteriologic technics and isolation of the agents causing anthrax, plague, cholera and tuberculosis. The discovery of anesthesia by Wells and Morton, the development of antiseptic surgery by Lister, the introduction of x-ray by Roentgen, the control of insect-borne diseases, based on the investigations of Manson, Ross and Reed, laid the foundation for much public health progress much later in the day.

The first half of the 20th century accelerated the tempo of scientific discoveries particularly relevant to public health advance. Protective measures against an increasing number of infections, and effective serum therapy for others have been provided by the science of immunology. Most of our knowledge of hormones and enzymes is the product of this century as is the whole science of nutrition.

The effectiveness of the sulfonamides gave new impetus in the 1930's to chemotherapy, almost the first since Erlich's discovery of arsphenamine. More recently, this has been overshadowed by the development of the antibiotics. Penicillin, streptomycin, aureomycin and chloramphenicol

are, we hope, only the forerunners of more powerful agents which may substantiate Pasteur's assertion that the germ diseases could be banished from the earth.

The effectiveness of the adrenocortical hormones against a wide variety of apparently unrelated diseases as demonstrated during the past year may prove to be as significant to the future of human health as was the first report which Pasteur made on fermentation in 1851.

Not paralleling these advances but moving slowly in the rear guard have come nation-wide public health practice and organization. Health departments were organized in the states only during the last decades of the last century. In 1914 the first few fulltime county health departments began to appear. Cities by this time were developing safe water supplies; milk pasteurization followed soon after. Increasing attention was paid to the health of mothers and children, the latter phase particularly having contributed so spectacularly to our average life expectancy. Dublin and Lotka report that a century ago more than one-sixth of all infants died before their first birthday. In 1900 the death rate was still one in eight. Now it has fallen to one in 30.

We should bear in mind, nevertheless, that the decline in the tuberculosis mortality in this country to less than one-fifth of its 1900 rate has been accomplished without significant medical knowledge regarding it. We still have no specific cure for tuberculosis nor any generally effective method of prevention. This dramatic reduction in what once was the leading cause of death illustrates the close inter-relationship between health and social progress generally. Higher standards of living, improved housing, better nutrition and better health education have been the vital factors. An important role, not only in reducing tuberculosis but many other diseases as well, has been played by labor legislation, i.e., shorter hours of work, protective legislation for women and children in industry and improved conditions in mills and factories.

By this reasoning, the most outstanding milestone in public health of this century is the Social Security Act of 1935 in which the financially minor health provisions have proven to be of even greater fundamental importance than the old age retirement, unemployment and other insurance benefits. The ensuing rapid expansion of federal grants-in-aid to the states for maternal and child health, for venereal disease and tuberculosis control, for curbing cancer and heart disease and for improving mental health are too recent and well known to require description.

In these successive programs one trend seems clear: That is that a majority of the people increasingly insist that Government—federal, state and local— accept health care of the citizen as a public responsibility, that all citizens through their governments assume an increasing responsibility for campaigns against all major causes of illness and death, whether or not scientific knowledge has as yet provided the precise tools for effective control. This insistance is, I think, quite understandable. Yet there are few communities and even fewer states in which everything now known is being used for the reduction of illness and the prevention of premature death. This is an expected "cultural lag." But the trend is clear and in my opinion will not be reversed or even halted.

A corollery to this trend is the popular demand that the progress of medical science be speeded up in its search for a basic understanding of the causes, prevention and cure of major health hazards. This is expressed not only through the millions being poured by the federal government into research and grants-in-aid to universities and other research centers, but also through the millions poured annually by voluntary gifts into such organizations as The National Foundation for Infantile Paralysis, The American Cancer Society, The National Tuberculosis Association, The American Heart Association and many others. This is a projection into health problems of today of what was termed in the last century "the sentiment against suffering."

Let me cite one example: Authority was given in 1937 to The National Cancer Institute of the U. S. Public Health Service to make limited grants to private institutions for cancer research and for training fellowships. This was expanded in broad language in the Public Health Act of 1944 to include any area of medical research and training, the construction of research facilities and the creation of separate institutes as successors to the National Institute of Health, each with a substantial budget, to deal completely yet with full coordination, with such problems as mental health, cardiovascular disease, microbiology, physiology and dental health.

The significance of the basic Act of 1944 which, in addition, recodified laws back to 1798 affecting the U. S. Public Health Service, and of its several supplements, is becoming clear in the great expansion of the program which your competent Surgeon General, Leonard A. Scheele, described last night.

After the long lags between our medical knowing and public health doing, the point at which a public health idea is definitely accepted by the people may be as important a milestone in human affairs as is a discovery derived from laboratory investigation.

I cite in this connection the Hill-Burton Act of 1946 and the report of the Commission on Hospital Care, made public in 1947. Hearings in the Congress on legislation and the studies of the Commission proceeded concurrently, each helpful to the other. Each recognized the expanded role of the hospital as a integral part of the health system of the future, "as the focal point through which the health system of the community is integrated," as a center for health education, for group practice of physicians, for research, especially clinical studies and investigations, and for undergraduate and postgraduate training of physicians, nurses, medical social workers and hospital administrators.

The concept of regional planning of hospitals also has been accepted. Nevertheless, their functional interrelationships are largely a promise of the future as are also their sponsorship of group medical practice and their affiliation with university centers of medical education.

Time does not permit an exploration of the potential of the World Health Organization in future history. Milestones obviously are the creation of the Health Section of the League of Nations following the first world war, the only section of the League, by the way, with which the United States officially collaborated, and the International Health Conference of 1946, at the close of which 61 nations signed the Constitution setting up WHO.

In any event, I think you will agree that international action in health at its best can but level up the backward areas of the world to national action at its best. In my opinion, the voice of the United States will be listened to with respect and its influence will be felt in WHO to a degree exactly proportionate with our demonstration at home of public health principles. I have a hearty personal distaste for urging upon others what we do imperfectly and incompletely ourselves.

Doctor Dyer's problems right here in West Virginia provide an excellent example of what I am driving at. He lists five major needs which he feels are basic. Unless these needs are met, public health progress will be seriously retarded. He says:

"1. We need basic minimal health services for all the people of the state. There are tremendous differences in the amount, kind and quality of services in different areas.

"2. The shortage of personnel is a sore spot. Some of the local staff members are handling two jobs; others just can not meet the demand for their services. Even though money is available, some areas are not getting services because there is no one to do the job.

"3. Staff members need basic training in modern public health concepts. This need exists in relation to new staff members as well as those already employed, and exists in all the public health professions.

"4. We need greater cooperation among official public health agencies, voluntary organizations, educational associations and various citizen groups. Voluntary organizations must re-evaluate their place in the scene. Other groups need to understand the contributions they can make. Coordinated activity is the keynote.

"5. The people of the state must better understand the local health services available. Those in areas without services, or with substandard services, need better to understand why services are needed and how they would benefit.

"Actually, the total of these needs forms one basic problem: better health services, more extensive services, more and better equipped people to carry on the work."

The famed Dr. Herman N. Biggs set up the first really professional health department of New York State in 1913 using the slogan "Public health is purchasable." It is interesting to note how the emphasis has changed in 30 years. Not one of Doctor Dyer's basic needs is a matter of money. And although West Virginia is more fortunate than many states as to its basic health laws, I think its problems are reflected in many other areas where, also, effective public health practice is not retarded for want of public funds.

A conference of this type could profitably use its entire program in a discussion of the real obstacles. I shall attempt to mention only one and that briefly.

As I see it, the central difficulty obstructing public health advance in this country as a whole is the overall shortage of physicians, especially young physicians, currently entering public health as a career. There are shortages in other classes of public health personnel as well, but ways and means of bridging those gaps are less formidable.

There is, for example, no overall shortage of engineers nor of facilities for training them. It should be possible to divert a larger proportion of graduates into public health fields. The number of nurses in public health represents a small proportion of the total of trained nurses. Better facilities for training nurses in public health and better salaries should attract more nurse leaders. In addition, the division of nurse education and nurse training into several groups according to the responsibilities they will assume offers another method of meeting the nurse shortage.

Many public health tasks can be done and done well by trained sanitarians. The Public Health Service is offering substantial assistance in expanding training facilities for them. There is an ample supply of young men with the basic education which would fit them for learning the special disciplines required. It should not be

difficult to recruit and train a sufficient number of young men and women as technicians in public health laboratories or as statisticians.

The serious bottleneck is in the availability of physicians, even though the organized medical profession is not convinced that in the twenty years ahead the expanding population will need substantially more physicians than were trained during the 1930's. From the evidence at hand, I am convinced that adequate medical care will not be provided for the people of this country and that adequate public health services can not be made available unless there is a substantial increase in the overall number of physicians. That the Congress considers the situation serious is evidenced by the fact that a bill in support of aid to medical education, with provision for other professional skills, is about to be reported to the floor of the House with strong bipartisan support. A similar bill was passed by the Senate during the last session.

Mountin and Pennell have made some authoritative studies in this field. I shall quote only two facts which of themselves highlight the whole issue. First, the studies show that in 1909 we had 149 practicing physicians for each one hundred thousand population. In 1949, we had only 137. Second, the American Medical Association admits that even with our vastly expanded population "there are fewer students now in medical schools than there were in 1905."

I am not going to ask you to write letters to the Congress about this. I am going to ask you to help Doctor Dyer and his colleagues get their share of the best and brightest, also the toughest-minded, and the finest natural leaders, for public health is no career for a weakling, of the young men and women now about to choose their specialties. Ask them to get in touch with the U. S. Public Health Service or with Doctor Dyer, for facts as to the careers open to them, the rewards, the qualifications necessary for a public health career.

The citizenry of each state also can do a good deal to insure its health department of a fair share of what medical brains are available. Is there real freedom from political patronage? Is there civil service tenure for the man and woman of competence, as well as a decent retirement system? Does the position pay a reasonable wage compared with those of the best states? Is there a residence clause in the employment requirements? Such clauses wreck the recruiting possibilities for a health department in a state without major medical centers including an accredited school of public health.

If my own adopted state of Pennsylvania were to answer this questionnaire, it would not receive a passing grade. But a good many citizens are beginning to be seriously concerned about the situation in which we find ourselves. Consequently, there is reason to believe it may not long endure.

You have been very patient while I have talked to you all the way from Henry VIII to the 81st Congress! If I have dealt at some length upon the past, which is prologue, it is only because it helps us to remember that we have come a long way. We need also to remember that we have a long way to go. Our daily task in public health is full of problems. Our road ahead is full of rocks; but in this mechanized world of ours it is no longer very difficult to blast them out of the road bed. It is our sense of direction and our sense of the importance of our task that matter.

In this connection, and in closing, I must tell you one of my oldest and best loved stories. A group of men across the street were working on a large building. A stranger stopped and said to one of them, "What are you doing?" The man answered rather crossly, "Can't you see that I'm a mason building a wall?" The stranger asked the same question of another man. He said, indifferently, "I'm setting a window frame at $3 an hour." But the third man of whom the question was asked, "What are you doing?" raised his eyes with a look of happiness and replied, "I am building a cathedral."

OUR STAKE IN SECURITY

All over the world there are medical questions which stagger human comprehension as they are first examined. Yet, it is entirely possible to bring early reassurance to many people in spite of dire predictions and widespread scare-stories of hopeless futility if war should ever come again. Perhaps the present situation is exaggerated by publicized opinions of individuals more or less prominent in their fields.

There has been insufficient cognizance given to overall possibilities as well as to man's past survival from risks of relatively equal magnitude for their times. Of course only the future will reveal the extent of catastrophe in those instances where people make no effort to save themselves. On the other hand, American medicine has never been prone to an attitude of hopeless acceptance of death or defeat.

A great good will come from "calm courage in the midst of tumult, that serenity of soul in danger, which is the greatest gift of nature for command" (Voltaire). Physicians will achieve more along that line perhaps than most others could. They should learn and actively teach Americans the facts concerning measures of potential success. Some may be employed in a precautionary and others in a reparative manner wherever our citizens might be exposed to man-made terrors of superbombs, biological attacks, psychological warfare and others yet to be presented sensationally or irresponsibly.—Col. William L. Wilson (MC), USA, in Medical Annals of the District of Columbia.

HERNIA INTO THE FORAMEN OF WINSLOW*

(REPORT OF A CASE)

By J. G. RENNIE, M. D.,
Huntington, W. Va.

Internal abdominal hernias are relatively uncommon, only 467 cases having been reported up to December 1939.[3] Of these, herniation through the foramen of Winslow is one of the rarer forms. Hansman and Morton[3] state that of the 467 cases collected by them, intra-abdominal hernias involving the foramen of Winslow occurred in 37, or 8 per cent. Of these 19 were in males and 6 in females, and in 12 the sex was not mentioned. Two additional cases, both males, have been reported since, one by Edwards and Stewart in 1943[1] aud one by Gillis in 1946.[2] Mortality of internal hernias is high. Watson[4] concludes that fully 50 per cent of these patients die and an even higher mortality attends herniation into the lesser omental bursa.

The foramen of Winslow is described as the opening between the greater and lesser peritoneal sacs. The boundary above is the caudate lobe of the liver, and below, the duodenum and hepatic vessels. The boundary in front is the lesser omentum which contains the hepatic artery, portal vein and common bile duct, and behind, the vena cava. This opening usually admits one finger but in older persons it often is even smaller due to adhesions. Predisposing causes of herniation into the lesser omental bursa are (1) an unusually large foramen of Winslow, (2) an abnormally long mesentery, and (3) excessive length or mobility of the intestine.[4] In addition to this, Gillis[2] describes increased intra-abdominal pressure as a cause. There are two types of hernia into the lesser omental sac:[2] (1) the type in which the small or large intestine enters the foramen of Winslow and becomes incarcerated in the lesser sac and (2) the type in which the intestine enters the lesser peritoneal cavity and then reenters the peritoneal cavity through the gastrohepatic omentum. Because of the relative rarity and high mortality in these hernias, the following case report is presented.

CASE REPORT

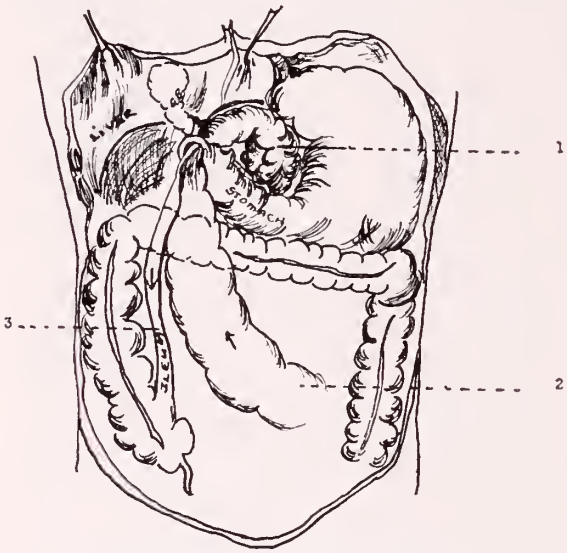
A 51 year old colored male was admitted to the Veterans Administration Hospital on 1/12/48 with a history of chronic constipation for the past three months. It was noted that he had been a patient in this hospital in January 1940, with post-traumatic arthritis of the left knee, chronic bronchitis and constipation. The present acute episode began with sudden vomiting following a cabbage supper 3 nights previously. He vomited several times and was unable to keep anything down after the onset of the present illness. He had passed no flatus and had had no bowel movements since 1/9/48, the beginning of his attack. Several enemata were returned clear. The examiner who first saw the patient on admission states that he vomited fecal-like material. Several days prior to admission he had had a cough. During the two days before he came to the hospital, the patient complained of cramp-like abdominal pains but when first seen the pain had subsided. He had had no previous similar attacks and no previous operations.

Physical examination revealed poor teeth, bilateral basal rales, blood pressure of 170/100, normal temperature, and pulse of 98. The abdomen was markedly distended with tympanitic percussion note on the left and flat percussion note on the right. No organs were palpable and there was insignificant tenderness. Except for a few high pitched peristaltic sounds in the left upper quadrant, the abdomen was silent. He was moderately dehydrated. The admission x-ray showed bilateral bronchopenumonia and the flat plate of the abdomen demonstrated dilatation of the proximal colon and marked distention of several loops of small intestine. The opinion of the radiologist was "obstruction of the terminal colon". The urine showed many white blood cells and a few red blood cells. The red blood cell count was 4,110,000, white blood cells 6,200, and hemoglobin 96%. He was started on penicillin and Wangensteen suction immediately following admission, with some improvement in his condition resulting, but since signs of obstruction persisted he was operated on at 2:30 p. m. on 1/13/48, approximately 38 hours after admission.

A left rectus incision was made in the lower abdomen because of the indications of large bowel obstruction in the x-ray. It was thought also that the obstruction was in the large bowel because of the patient's excellent condition despite nearly three days of obstruction. On opening the abdomen the small bowel was found to be somewhat discolored but by no means gangrenous; it was markedly dilated, with fluid levels present. The large bowel was normal in its entire extent. The ileocecal valve was marked with a Babcock clamp and the terminal ileum noted to be collapsed. The point off obstruction

*Sponsored by the Veterons Administration ond published with the opprovol of the Chief Medicol Director. The statements ond conclusions published by the outhor ore o result of his own study ond do not necessarily reflect the opinion or policy of the Veterons Administrotion.

was therefore searched for proximal to this. It was observed that the distal ileum could not be mobilized and it was thought at first that the mesentery was extremely short. It was necessary to extend the incision several inches upward in order to trace back the ileum. It was seen to go upward toward the right upper quadrant and it was impossible to draw the small bowel into view, it being necessary to follow its course cephalad by repeated applications of Babcock clamps. Just before the point of obstruction was located a finger was used to follow the ileum and it was found to enter the foramen of Winslow which admitted one finger with difficulty. It was at this point that the obstruction had taken place. The terminal ileum, about 3 feet from the ileocecal valve, had herniated into the omental bursa through the foramen of Winslow and had become incarcerated therein. Gentle traction brought out the incarcerated portion and ap-



HERNIA INTO FORAMEN OF WINSLOW

1. Herniated ileum incarcerated in the lesser omental bursa.
2. Dilated proximal loop of ileum.
3. Collapsed distal loop of ileum.

proximately 8 inches of the bowel was seen to be involved in the herniation. There was a pressure line around the circumference of the ileum at the point where it had been constricted by the foramen. After this maneuver had been completed, the foramen of Winslow admitted two fingers with ease. No particular abnormalities of the ileum were noted which could have caused this internal hernia.

After delivery of the intestine, the mesentery was examined and found to be of normal length. No Meckel's diverticulum or other abnormalities were present. Accordingly several hundred cc. of warm saline were instilled into the abdomen and the wound closed in layers with cotton sutures. During the first part of the operation, the patient had a marked blood pressure drop but soon recovered following the administration of 500 cc. of blood. On completion of the operation he was returned in good condition to his room. The postoperative course was very satisfactory. He soon began passing gas and on the 6th day the Wangensteen suction was shut off. On the 9th day the sutures were removed, the wound was well healed and the patient was allowed to walk. A gastrointestinal series taken postoperatively showed the esophagus, stomach and duodenum to be normal. In three hours the entire barium was found at the jejunum which was somewhat dilated, but there was no evidence of obstruction. The chest cleared, although on 1/22/48 there were still some exudative changes in the left lower lobe. Aside from sycosis barbae which responded to penicillin and sulfadiazine, the patient had no complications. The urine which had showed some pus when he first came in had cleared by 2/11/48. He was discharged on 2/12/48, one month following his admission, in excellent condition. This case had two of the predisposing causes mentioned, namely, a dilated foramen of Winslow and an increased intra-abdominal pressure which was caused most likely by chronic cough and chronic constipation.

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DOCTORS SHOULD CONSULT DOCTORS

As physicians, we know the priceless value of periodic examinations. These we constantly are recommending to our patients and the public. They have proven their merit to all. So much so, that more and more corporations are seeing the value of obtaining complete diagnostic studies for their executives as an important company investment. These have been called "pre-symptom diagnoses" by an able advocate of the comprehensive study of the presumably well individual. For instance, nearly 10 per cent of sigmoidoscopic examinations reveal polyps rarely demonstrated on the x-ray film that too often are pre-malignant. Not why have a proctoscopic—rather, why not?

Serial electrocardiographs are nowhere more important than in doctors of medicine, as our profession has the dubious distinction of leading all in succumbing to coronary heart disease. This is no plea for laboratory study as against a good history and physical examination. It is simply an appeal for doctors to consult doctors, sometimes, about themselves.—Ralph A. Johnson, M. D., in Detroit Medical News.

MEDICINE OF THE FUTURE

We may now contemplate in retrospect a fifty-year period of notable progress. We are, however, reminded that thirty of those fifty years were occupied by two wars and the uneasy breathing-space between them—not two separate wars, perhaps, but, as General Smuts has told us, one World War, the Thirty Years War of our modern age.

We note the quickened pace of discovery and the intensive and single-minded application of new and improved methods of therapy which are characteristic of all states of war. And we may chronicle with pride such achievements in peace as the control of diabetes and the grave anaemias; and, in war, the control of wound infection by penicillin, the control of malaria by new synthetic drugs, the effective treatment of shock and haemorrhage, and the prevention and treatment of the acute physical and mental stresses peculiar to training and battle.

All this new knowledge has already been incorporated in the techniques of contemporary practice. But we shall, I trust, continue to see these achievements in their true perspective. They provide no occasion for complacency. For we have to remember that the spectacular triumphs of the medicine and surgery of war have been mainly concerned with emergency situations—with acute disease and catastrophes—in which means of prevention or control could be envisaged and intensive and specific researches could be quickly launched.

But in the tragic field of malignant disease, and in the wide range of the degenerative diseases of man—non-lethal affections for the most part except in the long-term view—and still more in the special problem of an ageing population, our knowledge is still scanty and unprecise, and our therapeutic triumphs in the past are far from reassuring.

These long-term problems, which indeed are not lacking in urgency, constitute the outstanding and specific challenge to the medicine of the second half of the twentieth century. Our past experience should warn us not to look for rapid results in their solution. As in many of the comparable problems of science, our knowledge and understanding are likely to be illuminated by a patient study of fundamental processes and ideas.

With such a vista before us the liberal profession of medicine must surely continue to offer an attractive way of life. Much remainds to be done, however, to make the working conditions worthy of highly educated men and women.

General practice must be restored to its old importance, and the doctor must be relieved of many non-essential tasks which he is still called upon to perform. Some of us believe that this will come about from the establishment of group practice based on health centres where a wide range of ancillary services—secretarial, nursing, and so on—is available, and the control of beds in general practitioner hospitals both in the country and in the towns.

In the fields of specialist practice based on a hospital service our main requirements are generous budgets for research and travel, for the proper distribution of specialists, for the adaptation of old hospitals and the building of new ones, and, above all, to meet the high maintenance costs which modern advances in the art of medicine and surgery have imposed upon us.

If our profession fails to meet the social and scientific challenged of the modern age the "fault, dear Brutus," will lie, "not in our stars, but in ourselves."—Sir Harry Platt, M. D., M. S., in British Medical Journal.

NATIONAL BLOOD DONOR PROGRAM

We are all quite familiar with the tremendous amounts of whole blood, blood plasma and plasma fractions which were made available for use by the Armed Forces during the recent war, as well as the great part their availability played in the saving of lives and shortening of convalescence.

Fortunately, in 1942, there was still time for this country, through the efforts of the Red Cross, the National Research Council, the Army, the Navy, and the Public Health Service, to develop and operate a national blood donor program and then produce and ship blood and its derivatives in adequate or nearly adequate quantities to the areas in which our troops became engaged in major conflicts. The evidence would seem to indicate, however, that such a period of grace is not likely to exist in the event this country is faced with another national emergency, and it is imperative in the field of blood transfusion, as a part of necessary preparedness, that blood programs be developed on a nationwide basis, with some national coordination and control, if blood and its derivatives are to be promptly available in the event of need.

The establishment of such programs is, as a matter of fact, entirely justifiable if we are to be in a position to make full use of the therapeutic possibilities of human blood in normal times. In this regard the American National Red Cross has undertaken to support and assist in State, regional and local blood programs which have the approval and participation of the medical societies, health departments and hospital groups concerned.—John B. Alsever, M. D., in Connecticut St. Med Journal.

MEDICO-LEGAL ASPECTS OF SENESCENCE

It is the duty of every doctor, as with every citizen, to testify when called upon by a court of law, regardless of any personal inconvenience. This duty may be enforced by a court writ or subpoena commanding him to appear and testify in a certain court in a certain cause and on a certain named day. There is some question whether the doctor may be compelled to testify as an expert in court without extra compensation, but in other respects he is no different from any other man.

With increasing numbers of old people, the doctor may expect to become increasingly involved with medico-legal problems. When he is informed that he is to be a witness, he should prepare himself for the examination, should learn from the attorney what is expected of him and what his rights and privileges are.

Theoretically and practically, the expert witness is there to advise the judge and jury of the scientific problems involved. He can be of real value only if he can talk to the judge and jury in terms that they as laymen can understand.—Harold W. Lovell, M. D., in Geriatrics.

COLLEGE OF PHYS

The President's Page

The more I study the reports submitted by Dean Herman G. Weiskotten and Dean Wilburt C. Davison, concerning the advisability of constructing a four-year school of medicine and dentistry in West Virginia, the more I feel sure that their recommendations should be given favorable consideration by the legislature.

During the past few months I have visited nearly every section of West Virginia. The sentiment for a four-year school is pronounced in every area I have visited. Our people feel that if we provide a four-year school in this state, our medical and dental students would be more inclined to remain within the borders of West Virginia to practice their profession. While there is more outspoken sentiment in favor of the school in areas where there is a shortage of doctors and dentists, I have found no opposition whatsoever in any urban or rural communities.

The old building used as a two-year school in Morgantown is more than a disgrace to our state. The faculty at this school, which, incidentally, is composed of members who rank at the top of their respective teaching fields, is doing a fine job with antiquated facilities. Our students deserve better treatment at the hands of the state than can be afforded them in the building at Morgantown, which must be torn down soon in order that the building program for that part of the University campus may be completed.

It is nonsense to say that West Virginia cannot afford to build and maintain a four-year school. It is preposterous to think that any modern educational program will much longer tolerate a two-year school. West Virginia can and should build a four-year school, and funds for that purpose should be appropriated by the 1951 legislature.

Not only should we have a school, but we can have one if interested individuals and groups in every part of the state will unite in a campaign designed to convince the 126 members of the legislature that West Virginia can no longer deny a complete medical and dental education for our students who desire to fit themselves for practice in these worthy professions.

C. E. Watkins

President.

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SMOKING AND LUNG CANCER

In recent years a definite total and percentage increase in bronchopulmonary cancer has been noted by the profession. Several theories have been advanced as to the cause, among them tobacco smoking and the use of tar in road building. Heretofore the statistics as to tobacco have been rather contradictory, but two articles in the May 27 Journal of the American Medical Association suggest a significant relationship.

Excessive and prolonged use of tobacco, especially cigarets, seems to be an important factor in causing cancer which originates in the lungs, Ernest L. Wynder, B. A., and Dr. Evarts A. Graham of Washington University School of Medicine and Barnes Hospital, St. Louis, conclude.

Among 605 men with lung cancer, 96.5 per cent were moderately heavy to chain smokers for many years, compared with 73.7 per cent among the 780 men in the general hospital population without cancer, the St. Louis doctors point out. Among the cancer group, 51.2 per cent were excessive or chain smokers compared to 19.1 per cent in the general hospital group. "In general, it appears that the less a person smokes the less are the chances of cancer of the lung developing and the more heavily a person smokes the greater are his chances of becoming affected with this disease," they say.

Smokers were classified on the basis of number of cigarets smoked per day for 20 years or more. Pipe and cigar smokers were included by counting one cigar as five cigarets and one pipeful as two and a half cigarets. Light smokers were classified as smoking one to nine cigarets, moderately heavy smokers 10 to 15, heavy smokers from 16 to 20, excessive smokers 21 to 34 and chain smokers 35 or more.

However, there may be a lag period of 10 years or more between cessation of smoking tobacco and the occurrence of clinical symptoms of cancer, the St. Louis observers found. Among the patients with cancer who had a history of smoking, 96.1 per cent had smoked for over 20 years. The occurrence of carcinoma of the lung in a male nonsmoker or minimal smoker is a rare phenomenon (2.0 per cent), according to the study.

Tobacco seems to play a similar but somewhat less evident role in causing cancer in women, the doctors found. The incidence of lung cancer is less in women than in men today. This is believed to be due in part to the fact that few women have smoked for over 20 years.

There is rather general agreement that the incidence of bronchiogenic carcinoma has increased greatly in the last half century, the doctors point out. The enormous increase in the sale of cigarets in this country approximately parallels this increase of bronchiogenic carcinoma.

Among male patients with cancer of the lungs, 94.1 per cent were found to be cigaret smokers, 4.0 per cent pipe smokers and 3.5 per cent cigar smokers. This prevalence of cigaret smoking is greater than among the general hospital population of the same age group. The greater practice of inhalation among cigaret smokers is believed to explain the increased incidence of the disease.

Data obtained from 1,650 patients admitted routinely to the Roswell Park Memorial Institute, Buffalo, N. Y., indicate that in a hospital population cancer of the lung occurs more than twice as frequently among those who have smoked cigarets for 25 years than among other smokers or nonsmokers of comparable age, according to another study published in the same issue of the Journal.

"Pipe smokers apparently experience an almost equal increase in the incidence of lip cancer, compared with other smokers or nonsmokers," says Drs. Morton L. Levin, Hyman Goldstein and Paul R. Gerhardt of the Bureau of Cancer Con-

trol, New York State Department of Health, Albany.

"The data suggest, although they do not establish, a casual relation between cigaret and pipe smoking and cancer of the lung and lip. Cancer is now generally considered a disease attributable to multiple causative factors. Among these are 'irritants.'

"An irritant which is noncarcinogenic alone may nevertheless increase the percentage of tumors produced when its action is combined with that of a carcinogen. Thus, some experimental basis exists for explaining the apparent effect of cigaret and pipe smoking, although the true nature of the association with lung and lip cancer remains to be determined."

DEANS RECOMMEND SCHOOL

The reports submitted to the legislative interim committee by Dr. Herman G. Weiskotten and Dr. Wilburt C. Davison leave nothing to the imagination concerning what they think about a four-year school of medicine and dentistry in West Virginia. What will be done about the matter is for future determination by the legislature.

While the great need for the school is apparent to all those who have studied the matter, the appropriation of needed funds for the purpose is something that must be decided by the legislature itself.

We do know that there is an acute shortage of doctors and dentists in West Virginia. The need becomes more apparent as additional communities plead for help. The solution is, of course, the education of our own students who desire to pursue a medical or dental course. For too long a time has this great state delayed taking action.

If other states can expand their two-year schools into a four-year school, West Virginia can do likewise. It is difficult to explain to the hundreds of students who desire to study medicine and dentistry why they cannot complete their education in this state.

Every interested person, regardless of his business or profession, should talk with the candidates for the legislature, both senate and house, to ascertain their views concerning this vital question before the primary election August 1, 1950.

We hope that the interim committee studying the matter will submit a constructive building program that will promptly be enacted into law at the 1951 session of the legislature.

INTEREST IN GP PROGRAMS

For the second time in a little over a month, the West Virginia Academy of General Practice has helped bring to doctors in a given community in West Virginia a refresher program that has been received with the greatest of interest.

A program, arranged jointly by the Academy and the Barbour-Randolph-Tucker Medical Society, was presented at Elkins on June 15. The speakers discussed a variety of subjects of interest particularly to the general practitioner. This meeting followed closely the first program which was presented at Huntington, May 14, 1950.

If attendance counts for anything, the meetings that are being arranged by the Academy for the remainder of the year will prove to be a success. The attendance will be larger as the value of the programs becomes known to the doctors doing general practice in West Virginia.

The secretary of the Academy, Dr. Carl B. Hall, of Charleston, and the general chairman of the B-R-T committee, Dr. Hu C. Myers, of Philippi, deserve much credit for the high quality program arranged for the Elkins meeting, and we predict increasing interest on the part of general practitioners over the state in the meetings that are planned for July, September, October, and November.

TODAY'S RESPONSIBILITIES

In every human undertaking, there comes a time for action, a time for decision. You can describe it in the language of the marriage service, or — if you prefer — of the poker table, "Put up or shut up." No matter how you phrase it, the alternative of such a time cannot be denied.

This year is a time of decision that requires positive action on the part of the medical profession. If this action is not forthcoming, doctors cannot reasonably complain of the consequences.

This is a year in which the American people elect Senators and Congressmen to represent them in Washington. Under our system of Government, it's up to every citizen to work for the success of candidates in whose views he believes. Only through active effort can we have good Government.

This responsibility is now squarely before all doctors. If they are to be well represented they must work, and they must start now. Doctors, their families, and their friends must be registered. On election day — in primary balloting and in November — it's up to the doctors to help turn out the vote, the vote for their candidates.

There is only one way to preserve American freedom — medical freedom — under our democratic process. That way is the voting way, the electioneering way. It's the best way ever devised, but it poses responsibilities.

They are responsibilities no doctor can afford to sidestep. They are responsibilities that need meeting — today.

WE DO NEED A FOUR-YEAR SCHOOL

Do we need a four-year school of medicine and dentistry? This question has been answered in the affirmative many times and for many reasons during the past few months.

There now appears to be a new very important reason why we should provide a four-year medical education in our own state. This has to do with the acute shortage of interns and residents for service at West Virginia hospitals. Students graduating from medical schools are by the hundreds accepting internships provided by our armed forces, the Veterans Administration, and the more or less larger hospitals of the country. Likewise, it is hard for the smaller hospitals to compete in the matter of obtaining residents among those who are finishing their internships.

The advocates of a four-year school believe that if we furnish a complete education for our doctors in West Virginia many of those who graduate will remain in this state to serve their internship and possibly a residency.

There is no doubt about the shortage of interns and residents, and certainly the situation would be helped to a great extent were we in a position to offer our medical students a complete education in their home state.

THE 83RD ANNUAL MEETING

The fact that considerably over 500 doctors and their wives have made reservations at the Greenbrier for the 83rd annual meeting of the West Virginia State Medical Association, July 27-29, indicates that the attendance at the general sessions and meetings of sections and affiliated societies and associations will exceed that of last year.

Probably at no time in the history of the Association has there been a higher rate of attendance than at the sessions at the Greenbrier in 1949. The auditorium was always more than comfortably filled at the general sessions and in a few instances there was an overflow audience at section meetings in the afternoon.

We hope that every member of the State Medical Association reads the break-down of the program that appears in this issue of the Journal. It will be observed that every section and all affiliated societies and associations are represented. General sessions will begin at nine o'clock each morning, and most of the afternoon meetings are scheduled to begin at 1:30 o'clock.

We have heard much favorable comment concerning the fine work that has been done by the program committee. There is real interest and enthusiasm on the part of the speakers who have been selected to appear during the three-day meeting, and there is no doubt in the mind of any doctor that the program will prove to be one of best ever arranged for an annual meeting.

For the first time in many years, there will be no banquet speaker. Instead, the committee has, through the courtesy of the Weirton Steel Company, arranged for the appearance of the Weirton Male Chorus, with thirty-five voices, and the banquet will be preceded by a cocktail party in the Spring Room, which is being sponsored by the Greenbrier Clinic.

If there was ever a "must" for any member of the West Virginia State Medical Association, it is the annual meeting this year at the Greenbrier.

THE DOCTOR CENSUS

The 1950 edition of the American Medical Directory, edited by Frank V. Cargill, of the A. M. A. Headquarters Staff, is just off the press. It shows a healthy growth of the physician population, a trifle above 11.5% in eight years.

The new directory shows that the physicians of the United States are in the following classifications: 72,550 are in general practice, and 22,976 are in general practice but give some attention to a specialty; 54,891 limit their practice to a specialty; 12,536 are in federal government service; 9,700 are retired or in fields not related to medicine; 3,737 are in administrative, editorial or other executive positions related to medicine; and 24,887 are interns, resident physicians or full-time physicians in hospitals.

The previous directory, issued in 1942, listed the number of physicians in the United States as 180,496. In the 1950 edition the number is 201,277, an increase of 20,781 and an average yearly gain of 2,598 during the last eight years.

California leads in the number gained, with 16,668 physicians in 1950 as compared with 12,365 in 1942, an increase of 4,303. New York State shows a gain of 2,284; Texas, 772; Pennsylvania, 704; Florida, 634; and Massachusetts, 603.

Among the 24 largest cities in the United States, New York City (including Brooklyn) is

first in physician population with 17,915, an increase of 1,244 since 1942. Chicago is second with 7,477, a gain of 294; Philadelphia is third with 4,894, an increase of 649; Los Angeles is fourth with 4,183, a gain of 811, and Boston is fifth with 3,388, a gain of 454.

In 1940 there were 175,163 doctors, and the new directory shows an increase of 26,114 for the decade, a percentage growth of a little more than 14.9. The year 1949 shows a net increase in the physician population of the contiguous continental territory of the United States of 2,236, the total number of new licentiates being 5,836 and the deaths 3,600. Although the total population of the country for the current census has not been announced, it is evident that physician population and total population are increasing approximately *pari passu.*

A CALL FOR ACTION

We've just returned from this year's Rural Health Conference, sponsored by the West Virginia State Medical Association. As conferences go, this particular one was as good as any; but, we are beginning to believe that conferences alone won't solve our rural health problem here in West Virginia.

What we need is action — action on the county and community level. If such action is not soon forthcoming on the local scene, we can rest assured that it will come from Washington. With talk of socialized medicine becoming more and more prevalent, we can no longer be content with merely getting together once or twice each year to talk about our health problems.

The cold facts of the situation were presented in the May *Farm News.* The facts show that the rural health situation in West Virginia revolves around two main problems. With considerably less than one doctor per thousand population, and with the situation even worse in rural areas, it is clear that we need more doctors. With several counties in the state completely without hospitals, it is clear that we need more hospitals. In order to solve these basic needs, we must have leadership.

Who is going to provide this leadership? Should it come from organized farm groups, organized medical groups, organized business groups, or from government agencies? We believe that the solution to the problem lies in closer cooperation among all these groups, but that the initiative should come from local farm and medical groups.—*West Virginia Farm News.*

TUBERCULOSIS ABSTRACTS*

MULTIPHASIC SCREENING EXAMINATIONS

Public health workers are now directing their efforts to the control of the chronic diseases. Emphasis is correctly placed on prevention in chronic disease control in all fields of public health endeavor. The technique here presented is based on a fundamental concept in preventive medicine, the concept that early detection, early diagnosis, and adequate treatment can accomplish substantial reduction in disability and deaths from chronic disease.

This concept of preventive medicine is, of course, the basis for "periodic health examinations" which have been promoted during the past quarter of a century. These examinations, for the early detection of disease, are relatively expensive in terms of a physician's time and laboratory services. Viewed as a technique for chronic disease control, they have severe limitations.

A different approach to the detection of disease in its early stages has long been known to public health agencies. Mass chest x-ray surveys using photofluorographic equipment and mass serologic testing programs for the detection of syphilis are well-established methods. Recently, comparable screening techniques have been developed for early detection of diabetes, certain types of heart disease, and cancers of certain sites.

These screening procedures are capable of wide application; they are relatively inexpensive per person tested; and they require relatively little time on the part of the physicians. They have been used, for the most part, in separate case-finding programs. A population group in one city is screened for tuberculosis. In another, a group is screened for diabetes and, in still another, for syphilis. The question then arose—When we screen a population group for tuberculosis, why not also screen for syphilis, diabetes, heart disease, and cancer at the same time? The advantages of combined screening operations through a multiphasic screening procedure then become quite obvious.

For the individual who is served and for the administrative agency, it has many advantages. The discovery of active tuberculosis and early syphilis will vary with the type of population screened. However, for the adult population of the United States, the discovery rate of each of these diseases would probably be not less than 3 per 1,000. In the case of diabetes, studies have indicated that approximately 7 previously unknown cases per 1,000 persons tested would be discovered through blood-sugar and urine-sugar screening devices. A careful follow-up of persons whose miniature chest x-ray films disclosed abnormal cardiac shadows revealed that 10 per 1,000 of the group studied had previously unknown, clinically significant heart disease.

The multiphasic screening procedure, through which 20 to 30 cases of significant disease may be discovered per 1,000 persons tested, constitutes a practical approach to the present-day problems in preventive medicine. This preventive technique—designed for the early detection of groups of these diseases—merits further consideration, study, and exploration.—Lester Breslow, M. D., in Am. J. PH, March, 1950.

*Issued monthly by the National Tuberculosis Association and furnished through the courtesy of The West Virginia Tuberculosis and Health Association.

GENERAL NEWS

LARGE ATTENDANCE ASSURED FOR 83RD ANNUAL MEETING, JULY 27-29

Arrangements for the 83rd annual meeting of the West Virginia State Medical Association have been completed except for minor details that will have to be worked out a few days before the opening session on Thursday, July 27, 1950.

The registration booth just outside the main entrance to the auditorium will be opened Wednesday afternoon, July 26, at 3:00 o'clock, and will remain open each day during the meeting. The advance registration of doctors at the headquarters offices in Charleston passed the one hundred mark the middle of June. Reservations for doctors and their wives at the Greenbrier already total more than 550.

Pre-Convention Meeting of Council

The Council will meet in pre-convention session Wednesday, at 4:00 o'clock, and the members will be faced with the consideration of probably the heaviest agenda ever arranged for any previous meeting.

Dr. Charles E. Watkins, of Oak Hill, president of the State Medical Association, will call the first general session to order Thursday morning, July 27, promptly at 9:00 o'clock. The program committee has stated that, in order to allow plenty of time for guest speakers, general sessions each morning will begin at 9:00 o'clock.

Charles E. Watkins, M. D.

Elmer L. Henderson, M. D.

Most of the afternoon meetings of sections and affiliated societies and associations are scheduled for 1:30 o'clock, although a few will not convene until 2:00 o'clock.

The complete program for general sessions and afternoon meetings is printed in this issue of the Journal.

MCV Faculty to Present Program

Dr. E. J. Van Liere, dean of West Virginia University School of Medicine, will preside at the first general session Thursday morning, July 27. The entire program, whih will be devoted to a discussion of gastrointestinal diseases, will be presented by the faculty of the Medical College of Virginia, and Dr. Kinloch Nelson, professor of clinical medicine and director of continuation education, will serve as moderator. There will be a panel discussion of the papers presented at the morning session.

General Sessions Friday and Saturday

Dr. Richard E. Flood, of Cove Station, Weirton, a member of the program committee, will preside as moderator at the morning session on Friday, July 28. Dr. George M. Curtis, professor of experimental surgery at Ohio State University, will open the program, which will include addresses by Dr. Allan C. Barnes, professor of obstetrics and gynecology at Ohio State University, and Dr. Howard F. Polley, of the Mayo Clinic, Rochester, Minnesota.

Dr. Philip Thorek, of Chicago, will be the first speaker at the final general session on Saturday morning. Dr. J. P. McMullen, of Wellsburg, will preside at that

session, which will also feature addresses by Dr. H. B. Mulholland, professor of practice of medicine, University of Virginia Department of Medicine, Charlottesville, and Dr. Earl H. Baxter, professor and head of the department of pediatrics at Ohio State University, Columbus. The program Saturday morning will be closed with an address by Dr. Frank H. Lahey, of Boston. A question and answer period will follow the presentation of each paper.

Presidential Address

The presidential address is scheduled for Thursday evening, July 27, at 9:00 o'clock. After the address, the president's charm will be presented to Dr. Charles E. Watkins, of Oak Hill, by Dr. Thomas G. Reed, of Charleston, chairman of the Council.

Short addresses will be delivered by Mrs. Dana T. Moore, of Parkersburg, president of the Woman's Auxiliary to the West Virginia State Medical Association, and Mrs. Arthur A. Herold, of, Shreveport Louisiana, president of the Woman's Auxiliary to the American Medical Association. Dr. J. C. Huffman, of Buckhannon, vice president of the West Virginia State Medical Association, will preside at the evening session.

AMA President Guest Speaker

Dr. Elmer L. Henderson, of Louisville, Kentucky, who will be installed as president of the American Medical Association at the AMA meeting in San Francisco late in June, will be the guest speaker at the evening session on Friday, July 28. This evening meeting is also scheduled to get under way at 9:00 o'clock and the speaker will be presented by Dr. Charles E. Watkins.

Whitaker and Baxter at Open Meeting

Immediately preceding the first meeting of the House of Delegates on Thursday afternoon, July 27, there will be an open meeting in the auditorium with Clem Whitaker and Miss Leone Baxter as guest speakers. This meeting is scheduled for 3:30 o'clock and the speakers will be introduced by Dr. Charles E. Watkins, the president. Mr. Whitaker and Miss Baxter will discuss the American Medical Association's National Education Campaign, and the occasion will mark their first appearance in West Virginia since the inauguration of the campaign early in 1949.

House of Delegates

The first session of the House of Delegates is scheduled for 4:30 o'clock Thursday, July 27, and the final session, at which officers for 1951 will be elected, will convene at 3:30 Friday afternoon.

MCV Alumni Dinner

The annual Medical College of Virginia alumni dinner will be held Thursday evening at 6:30 o'clock at the Greenbrier. The guest speaker will be Dr. Donald S. Daniel, of the Johnston-Willis Hospital, Richmond,

Clem Whitaker and Leone Baxter

Virginia. Doctor Daniel is president of the Alumni Association. The dinner will be preceded by a social hour, which is scheduled for 5:30 o'clock. Arrangements for the affair are in charge of Mrs. Helen M. Seller, of Richmond, assistant secretary of the MCV Alumni Association.

Golf and Tennis Tournaments

The annual golf and tennis tournaments will be held as usual with play limited to afternoons of the meeting. Horseback riding is one of the feature attractions at the Greenbrier with good riding horses available for use on the miles of trails within the Greenbrier grounds. The swimming pool will be open each day, and there will be dancing each evening.

Dr. S. S. Hall Toastmaster at Banquet

The convention will close with the annual banquet Saturday evening, July 29. Dr. Sobisca S. Hall, of Clarksburg, will serve as toastmaster. Dress will be informal for the banquet and for all other functions during the convention.

Since announcement was made early in the spring that the famous Weirton Male Chorus would appear at the banquet, interest has increased to such an extent that there is no doubt that the banquet will be a sell-out affair.

Last year, 515 doctors and their wives and guests crowded the auditorium to hear Dr. Will Durant, the speaker at the annual banquet. An additional 35 had to be seated in the main dining room. Seating arrangements in the auditorium had to be rearranged twice and the dinner got under way nearly an hour late.

This year, an absolute limit of 400 persons has been placed on attendance at the banquet. This step has been taken by the management of the Greenbrier in the interest of safety for those who may be present. The normal capacity of the auditorium is 400 and no tickets can be sold in excess of that number.

Feature Attraction at Banquet

The Weirton Male Chorus, which enjoys a national reputation, is composed of 35 voices, and this famous organization will appear through the courtesy of the Weirton Steel Company. The president of the company, Mr. Thomas E. Millsop, will be present at the banquet.

The chorus is made up of employees of all departments of the Weirton Steel Company and is under the direction of T. Herbert Davies, and the accompanist is Gerald Ferguson. The chorus is under the direct supervision of R. M. Corll, manager of the industrial relations of the Weirton Steel Company.

There will be no speaking program, but distinguished guests will be introduced and awards will be made to winners of the golf and tennis tournaments.

As this issue of the Journal goes to press (June 23), reservations for rooms at the Greenbrier have been made by more than 550 doctors and their wives. In addition, several rooms have been reserved at the other hotels in White Sulphur Springs.

MRS. ROSS P. DANIEL TO BE INSTALLED AS PRESIDENT OF WOMAN'S AUXILIARY

Mrs. Ross P. Daniel, of Beckley, will take office as president of the Woman's Auxiliary to the West Virginia State Medical Association Saturday, July 29, during the 26th annual meeting which will be held conjointly with the State Medical Association's 83rd annual meeting at the Greenbrier, in White Sulphur Springs, July 27-29. She will succeed Mrs. Dana T. Moore, of Parkersburg.

Mrs. Daniel and all other elective officers will be installed by Mrs. Arthur A. Herold, of Shreveport, Louisiana, president of the Woman's Auxiliary to the American Medical Association.

Registration of members will open Thursday afternoon, July 27, in the Virginia Room, and the pre-convention meeting of the Board will be held at 4:00 o'clock, with Mrs. Dana T. Moore, the president, presiding.

Past President's Breakfast

The past president's breakfast is scheduled for 8:00 o'clock Friday morning, July 28, with Mrs. W. E. Hoffman, of Charleston, presiding. The formal opening of the convention is set for 9:30 o'clock in the Virginia Room.

Annual Luncheon

The annual luncheon in honor of past presidents will be held Friday afternoon at one o'clock, and guests will include Dr. E. L. Henderson, president of the American Medical Association, Mr. Clem Whitaker and Miss Leone Baxter, in charge of the AMA National Education Campaign, Mrs. W. E. Hoffman, third vice president of the Woman's Auxiliary to the AMA, and the

Mrs. Dana T. Moore

Mrs. Arthur A. Herold

presidents of the Ohio and Pennsylvania State Auxiliaries.

Other honor guests will include Dr. and Mrs. C. E. Watkins of Oak Hill, Mrs. E. L. Henderson, of Louisville, Kentucky, and Drs. Paul L. McCuskey, William A. Thornhill, Jr., Frank J. Holroyd, Elizabeth McFetridge, and E. H. Starcher, members of the state advisory board to the Woman's Auxiliary. Mrs. S. William Goff, of Parkersburg, will preside at the luncheon.

Election of Officers

New officers will be elected at the session on Saturday morning, July 29, and reports of county presidents will be received at that time. The formal meeting will be closed with the inaugural address of the new president, Mrs. Ross P. Daniel.

Notionol President Honor Guest

Mrs. Charles L. Goodhand, of Parkersburg, will preside at the luncheon Saturday honoring Mrs. Arthur A. Herold and Mrs. Ross P. Daniel. The principal address will be delivered by Mrs. Herold.

Mrs. Herold has been active in Woman's Auxiliary work for the past 20 years. She has served as chairman of legislation, constitutional secretary, treasurer, convention parliamentarian, and as a member of numerous active committees of the Woman's Auxiliary to the American Medical Association. She is a past president of the Woman's Auxiliary to the Louisiana State Medical Society, and also a past president of the Woman's Auxiliary to the Southern Medical Association.

Mrs. Herold is a graduate of the H. Sophie Newcomb College of Tulane University, and has always been active in the work of the American Association of University Women and the American Cancer Society. She was installed as president of the Woman's Auxiliary to the American Medical Association at the annual meeting at San Francisco late in June.

Post-Convention Boord Meeting

The post-convention meeting of the board will be held in the Virginia Room at the Greenbrier, Saturday afternoon, at 3:00 o'clock, with Mrs. Ross P. Daniel presiding.

Entertainment provided by the Auxiliary for members and their husbands will include dancing, bridge and Canasta. There will be a dance each evening, and the members will attend the annual banquet with their husbands Saturday evening at seven o'clock.

Record Attendonce in 1949

The 1949 annual meeting of the Woman's Auxiliary drew a record attendance of 182 members, twenty more than the total reached at any previous meeting. Auxiliary officers expect a new attendance record to be set at the forthcoming annual meeting in July.

"DENTIST OF THE HALF CENTURY"

Dr. Norman H. Baker, of Charleston, acting director of the Bureau of Dental Health Work, has been named by the American Dental Association as West Virginia's "dentist of the half century." Announcement of his selection was made in a special mid-century issue of the Journal, commemorating 50 years of dental progress.

The announcement states that Doctor Baker was chosen for the honor "in recognition of his outstanding services in state public health work." He is credited with the establishment of an oral hygiene division in the state department of health. The division later became the bureau of dental health. At the present time he is the dental member of the advisory committee to the division of maternal and child health. He is a past president of the West Virginia State Dental Society and has served as a member of the judicial council of the American Dental Association.

Doctor Baker served several years as a member of the public health council before the creation of the new medical licensing board.

VIRGINIA UROLOGISTS INVITED TO MEETING

All members of the Virginia Medical Society engaged in the practice of the specialty of urology have been invited to attend a meeting of the Section on Urology of the West Virginia State Medical Association at White Sulphur Springs, Saturday, July 29, during the Association's annual meeting. The invitation was extended by Dr. Ray M. Bobbitt, president of the Section.

USPHS APPROVES REVISED PLAN FOR HOSPITAL CONSTRUCTION IN STATE

The revised plan for the allocation of federal funds for hospital construction in West Virginia, recently submitted by Dr. N. H. Dyer, state director of health, has been approved by the United States Public Health Service. The plan does not change the minimum standard requirements, but does set up a new priority list upon the basis of which funds are allocated to state localities.

Under the amended Hill-Burton Act, a local community in West Virginia will now receive from the federal government 62.9 per cent of the total construction cost of a hospital. Local funds will be required to the extent of 37.1 per cent. Under the old bill, federal funds were provided to the extent of only one-third of the cost.

AA Priarity Rating

Localities with an AA priority, the highest priority in the hospital construction program, include Kingwood, Webster Springs, Grantsville, Winfield, Whitesville, Ripley, and Weirton.

A Priority Group

The A priority group includes Martinsburg, Point Pleasant, Hinton, Spencer, Madison, and Richwood.

Facilities Available, 50 ta 100 Per Cent

Localities with facilities available to meet only 50 per cent of the needs include Petersburg, Logan, Mullens, Buckhannon, Philippi, New Martinsville, Fairmont, Keyser, and Ronceverte.

The following cities are included in the group of cities with facilities to serve 50 to 75 per cent of present needs: Parkersburg, Marlinton, Clarksburg, Morgantown, Welch, Bluefield, Williamson, Huntington, and Wheeling.

Areas with facilities capable of serving from 75 to 100 per cent of the needs include Charleston, Charles Town, Elkins, Grafton, Beckley, Berkeley Springs, Oak Hill, Sutton, and Weston.

Applicatians Pending

According to the June issue of West Virginia Health News, applications for federal funds for the construction of new hospitals have been received from the following cities: Webster Springs, Whitesville, Weirton, Martinsburg, Richwood, Philippi, and Huntington.

Communities which have asked for funds to construct additions to present hospitals include New Martinsville, Fairmont, Parkersburg, Clarksburg, Welch, Wheeling, Charleston, and Huntington.

Community Health Centers

Applications have been received for federal funds for the construction of health centers at Moundsville, Beckley, Lewisburg, and Welch.

$5,000,000 Available July 1

On July 1, 1950, West Virginia will receive an additional $2,787,048 from the federal government for hospital construction. Added to the unused balance allocated for the fiscal year ending June 30, 1950, there will be available approximately $5,000,000 for the hospital construction program in this state.

WVU ALUMNI ADOPT RESOLUTIONS OF RESPECT TO MEMORY OF DR. R. B. BAILEY

The following is a copy of a resolution introduced by Robert H. C. Kay, of Charleston, and unanimously adopted by the West Virginia University Alumni Association at its annual business meeting at Morgantown, June 3, 1950:

It is with deepest regret that members of the West Virginia University Alumni Association, in annual meeting assembled, take note of the passing on September 15, 1949, of Dr. Russell Brooks Bailey.

A great son of West Virginia and its State University, Doctor Bailey's life was one of service to his fellowmen. His professional career was distinguished both from the standpoint of his skill as a surgeon and from his contributions to the advancement of medical science in the state and the nation.

He was widely known and respected not only in Lewis County, where he was reared, in Monongalia County, where he was educated, and in Ohio County, where he practiced medicine for more than twenty years, but throughout the entire State of West Virginia.

Aside from his family and his profession, Doctor Bailey had no greater love than that for his University. He had served it unselfishly in many ways dating from the day he first wore a West Virginia football uniform at the beginning of an intercollegiate athletic career which led to a place on the All-American team.

Just as the members of his profession had honored him by electing him to the presidency of the West Virginia State Medical Association just a few short months before his death, the Alumni Association had paid him similar honor in its field by choosing him for membership on its Executive Council on May 31, 1947. A year ago he was elected to the second vice-presidency of the Association.

The members of the West Virginia University Alumni Association join with the citizens of the State of West Virginia in paying their respects to Doctor Bailey—a native son and an alumnus who brought honor to himself, to his State, and to his University.

The sympathy of this Association is herewith extended to the family of Dr. Russell Brooks Bailey, and the Secretary of the Association is herewith instructed to cause this expression of respect to be spread upon the minutes of this meeting and to send a copy to the family and to the President of the University.

GREENBRIER CLINIC SPONSORS PARTY

A cocktail party will be sponsored by the Greenbrier Clinic in connection with the banquet of the West Virginia State Medical Association at the Greenbrier, in White Sulphur Sprngs, July 29. The party will be held from six to seven o'clock in the Spring Room. The banquet will get under way at seven o'clock.

It will be recalled that the Greenbrier Clinic was one of the co-sponsors of the cocktail party at the annual meeting in 1949, which was attended by over 500 doctors and their wives and guests. The Clinic will be the sole sponsor of the party this year.

DOCTOR ESPOSITO CERTIFIED

Dr. Albert C. Esposito, of Huntington, has been certified as a diplomate of the American Board of Ophthalmology. Doctor Esposito was formerly an instructor at Ohio State University College of Medicine

B-R-T AND WEST VIRGINIA AGP SPONSOR JOINT MEETING AT ELKINS

The joint meeting of the Barbour-Randolph-Tucker Medical Society and the West Virginia Academy of General Practice, held at Elkins June 15, drew a record attendance of doctors from the B-R-T area.

The meeting was held at the Tygarts Valley Country Club, with Dr. Hu C. Myers, of Philippi, serving as the general chairman. The scientific program was arranged by Doctor Myers and Dr. Carl B. Hall, of Charleston, secretary of the West Virginia Academy of General Practice.

The following scientific program was presented during the afternoon:

"Preventing Medico-Legal Pitfalls."—Mr. Rex Roth, Wheeling, supervising adjuster for the Aetna Casualty & Surety Company.

"The Early Diagnosis of the Acute Abdomen."—Warfield M. Firor, M.D., Baltimore, associate professor of surgery, University of Maryland School of Medicine, and chairman of the American Board of Surgery.

"Diarrhea in Infants."—McLemore Birdsong, M.D., Charlottesville, Virginia, associate professor of pediatrics, University of Virginia Department of Medicine.

"Recent Advances in Hematology."—Milton S. Sacks, M.D., Baltimore, associate professor of medicine and head of the department of clinical pathology, University of Maryland School of Medicine.

A banquet followed the social hour, and the principal speaker was Mr. Thomas A. Hendricks, of Chicago, secretary of the American Medical Association Council on Medical Service. His subject was, "The AMA—What, Why and How."

The speaker discussed the various activities of the AMA, emphasizing the important part that the firm of Whitaker and Baxter has played in the National Education Campaign. He recommended continued vigilance on the part of the members of the medical profession and cautioned against over confidence because of reverses the bureaucrats in Washington have recently suffered in their attempts to force the issue of compulsory health insurance.

Preceding the address by Mr. Hendricks, Dr. McLemore Birdsong of Charlottesville, Virginia, at the request of several of the doctors present, spoke briefly on the subject of "Acute Laryngotracheo Bronchitis."

Dr. C. E. Watkins, of Oak Hill, president of the West Virginia State Medical Association and Dr. J. C. Huffman, of Buckhannon, vice president, were guests at the meeting, and Doctor Watkins discussed briefly the important matters that are to be considered at the forthcoming session of the Association's House of Delegates.

Dr. Carl B. Hall reviewed the work that has been done by the West Virginia Academy of General Practice, and outlined the schedule of meetings that will be held in various parts of the state during the fall and early winter months. He reported that the growth of the Academy has been steady and that there is more interest now than at any time since the Academy was organized.

Charles Lively, executive secretary of the West Virginian State Medical Association, served as toastmaster at the banquet. He was introduced by Dr. C. L. Leonard, president of the B-R-T Medical Society.

After the speaking program, two movies were shown, one through the courtesy of Dr. Warfield M. Firor with the title "Alteration of Benign Cells Into Malignant Cells," and the other, "Cardiovascular Pressure Pulses," supplied by the G. D. Searle Company.

WEST VIRGINIA GRADUATES AT MCV

The degree of doctor of medicine was awarded to 92 students at the 113th Commencement of the Medical College of Virginia, Richmond, June 6. The following West Virginia students at MCV received a doctor of medicine degree:

Earl D. Allara, Iaeger; Thomas W. Ayres, Richwood; Kenneth L. Clark, Charleston; Ira Connolly, Jr.; Parkersburg; John J. Coogle, Rivesville; Robert C. Cowan, Jr., Morgantown;

William V. Crabtree, Wellsburg; John M. Foley, Fairmont; Dorsey C. Gamsjager, Grafton; Charles M. Garrett, Jr., Weston; Florine K. Hampton, Kermit;

Ward Harshbarger, Jr., St. Albans; John W. Hesen, Jr., Morgantown; Jane McMullen, Wellsburg; Harvey A. Martin, Keyser; Andrew J. Pasquale, Williamson;

Thomas C. Royer, Morgantown; Lee W. Shaffer, Jr., Parkersburg; Leo F. Sherman, Beckley; Robert D. Shreve, Glenville; Joseph A. Smith, Sutton; and Mary E. Zumbrunnen, Parkersburg.

The degree of doctor of dental surgery was awarded to one West Virginian, Thomas E. King, of Marlinton, and Barbara J. Powell, of Saint Albans, was awarded the degree of bachelor of science in pharmacy.

The degree of bachelor of science in nursing education was awarded to Margaret D. Arbuckle, Lewisburg; Lyda A. Bullington, St. Albans; Nancy P. Dailey, Kingwood; Norma J. Hess, East Beckley; and Clara R. Jones, Romney.

Two West Virginians graduated in physical therapy, Durward R. Funk, of Rowlesburg, and Agnes P. Snyder, of St. Marys.

For the first time in its history, an honorary master of science degree in general medicine was awarded. The recipient was Dr. James D. Hagood, of Clover, Virginia. The degree was given by the college as a means of recognition in the field of general medicine.

RELOCATIONS

Dr. H. W. Snodgrass, of Spencer, has accepted a three-year residency in surgery at Jackson Memorial hospital, Miami, Florida, effective July 1, 1950.

* * * *

Dr. John D. German, formerly of Huntington, who is now located at Clintonville, Wisconsin, has been appointed consultant in surgery at the 250-bed Veterans Administration Hospital at Iron Mountain, Michigan. Doctor German maintains offices at 12½ South Main Street, in Clintonville.

* * * *

Dr. Don V. Hatton, formerly of Huntington, has located at Oak Hill, where he will serve as internist on the staff of the Oak Hill Hospital. He has recently been connected with the Veterans Administration hospital at Louisville, Kentucky.

RABIES INCREASE IN 1950

More than twice as many cases of rabies have been reported thus far in West Virginia in 1950 than in any previous year. According to Dr. H. C. Huntley, director of the bureau of disease control of the state department of health, the greater number of the 183 cases reported to June 10 occurred in Kanawha county, with Cabell county being the second highest reporting area. This is the first full year in which rabies in animals have been reported to the state health department. In previous years, animal rabies have been reported by veterinarians over the state to the state department of agriculture.

Doctor Huntley states that while diseases may occur in any warm-blooded animal, 85 to 90 per cent of the cases reported in the United States are from dogs. Most human infections occur from this source. "Various methods for the control of rabies have been tried in different areas," says Doctor Huntley, "with it being generally agreed that it is most desirable to remove stray dogs from our canine population and vaccinate the remainder."

A voluntary immunization program of all dogs in Kanawha county was begun in March, 1950, and over fifteen thousand dogs have received the treatment. The effectiveness of the procedure has not been determined. However, Doctor Huntley recommends that dogs be chained or confined for a period of observation after exposure.

NEW COMMISSION ON CHRONIC ILLNESS

The National Foundation for Infantile Paralysis has appropriated the sum of $5,000.00 to further the work of the new national Commission on Chronic Illness.

According to Dr. Morton L. Levin, the director, the Commission, with headquarters at 535 North Dearborn Street, Chicago, is engaged in an education-research program and represents the first national unified approach to the common problems of the various forms of long-term illness. Other agencies which have pledged financial support in this cooperative enterprise are the American Cancer Society, American Heart Association, American Medical Association, National Tuberculosis Association, National Society for Crippled Children and Adults, and the New York Foundation.

A nationwide survey of present activities and plans in chronic disease control is under way, and a model community survey plan is being developed for use by communities interested in studying their local needs, services and facilities. The plan will be tested in several communities this summer before it is presented for use throughout the country. Plans have also been drawn up for a definitive study of prevalence and medical needs in an urban and a rural area.

HEART CLINICS FOR INDIGENTS

Announcement has been made that clinics sponsored by the West Virginia Heart Association are for indigent and medical indigent patients only. No examinations are provided patients who are able to pay consultation fees.

STATE BOARD OF HEALTH APPROVES MERGER OF DIVISIONS AND BUREAUS

At a meeting of the State Board of Health, held June 9 at Charleston, the reorganization of divisions and bureaus and revision of health regulations recommended by Dr. N. H. Dyer, state director of health, were approved without change.

Under the reorganization plan, the division of cancer control, the division of communicable disease control, and the bureau of tuberculosis control are combined in the new Bureau of Disease Control, and the division of sanitary engineering and the bureau of industrial hygiene are merged in the new Bureau of Environmental Sanitation.

The nutrition service of the state health department, formerly administered through the division of maternal and child health, will function as a separate bureau. The reorganization plans will not affect present personnel.

The Board authorized the bureau of industrial hygiene to proceed with a check on X-ray shoe fitting machines in West Virginia to determine if they constitute a health hazard.

Appointments of the following health officers were approved by the Board: Dr. Alexander Carr, District No. 2, Lewisburg; Dr. C. C. Coffindaffer, District No. 5, Romney; and Dr. B. S. Brake, District No. 3, at Pt. Pleasant.

EMERGENCY CALL SYSTEM IN KANAWHA

The Kanawha Medical Society has announced the inauguration of a new round-the-clock emergency call system for its members. It is the hope of the Society that the county-wide voluntary cooperative plan now in operation will make a doctor available at any time of the day or night.

The Bureau of Physicians and Registered Nurses will be the clearing house for emergency calls.

According to the president, Dr. T. Maxfield Barber, the new call system was worked out after several months' planning by the Society's public relations committee headed by Dr. William B. Rossman of Charleston.

SUPPORT SOUGHT FOR PH ACTIVITIES

At a meeting of the executive committee of the West Virginia Public Health Association held June 2, at the West Virginia Training Center in South Charleston, Miss Annette King, public relations representative of the State Department of Health, was unanimously reelected secretary.

The committee went on record as being in favor of a campaign for the education of the people of the state to the great need for support of public health activities. The matter of a specific project for the coming year is being studied by a sub-committee, which will report back at the next meeting of the executive committee.

The secretary was directed to mail a letter to members of the Association, asking that each endeavor to obtain one new member before the annual meeting in 1951.

DOCTORS TO SERVE HOSPITAL TOUR OF DUTY

In an effort to provide the maximum of good medical care and to offset to some extent the lack of interns and residents, the staff of the St. Francis hospital, Charleston, on June 8, 1950, adopted a resolution calling upon all active, associate, and courtesy members to accept voluntarily a 24-hour tour of duty in the hospital, following a regular alternating schedule. Physicians who cooperate will serve as house physician without compensation. The new system will be placed in effect July 1. The staff decided upon this drastic move in an effort to solve partly the problem of the shortage of interns and residents.

The shortage seems to be countrywide, and hospitals in every state apparently are similarly affected. Graduates of medical schools are accepting commissions in our armed forces, and employment in Veterans Administration hospitals and the larger hospitals of the country. It is almost impossible for the smaller hospitals to compete in the matter of the salary range provided.

It is reported that some of the smaller hospitals are being compelled to employ doctors and pay salaries considerably above the rate paid interns and residents. Doctors so employed usually serve a mixed residency.

STATE ANESTHESIOLOGISTS HONORED

At a meeting of the Potomac Society of Anesthesiologists held May 31, in the Medical Society Auditorium, in Washington, D. C., the following officers were elected for the new year: President, Donald H. Stubbs, M.D., Alexandria, Virginia; president elect, William E. Bageant, M.D., Washington, D. C.; vice president, John J. Mattare, M.D., Chevy Chase, Maryland; and, secretary-treasurer, Joel B. Hoberman, M.D., Arlington, Virginia.

Dr. John F. Morris, of Huntington, and Dr. S. Elizabeth McFetridge, of Martinsburg, were named to the eight-member executive committee.

The Society, which was founded in March, 1948, is composed of over 100 physicians located in Virginia, West Virginia, Maryland, and the District of Columbia. The object is "the advancement of the science and art of anesthesiology, especially in Virginia, West Virginia, Maryland and the District of Columbia, as well as to stimulate interest and promote progress in the specialty of anesthesiology."

ACP FELLOWSHIPS IN MEDICINE

The American College of Physicians has announced that a limited number of Fellowships in Medicine will be available from July 1, 1951, to June 30, 1952. The Fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are primarily for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in internal medicine.

The stipend will be from $2,200 to $3,200, and application forms, which must be submitted in duplicate not later than October 1, 1950, may be obtained from the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa. Announcement of awards will be made in November, 1950.

MORE PRIZES FOR GOLF TOURNAMENT

Additional prizes have been made available to the golf tournament committee for distribution in connection with the annual tournament at White Sulphur Springs during the 83rd annual meeting of the West Virginia State Medical Association, July 27-29.

Besides the grand championship trophy, which is being offered by the Kloman Instrument Company, of Charleston, valuable prizes will be awarded by the following: Max Wocher and Son Company, Cincinnati; McLain Surgical Supply, Inc., Wheeling; The Medical Arts Supply Company, Huntington; Feick Brothers Company, Pittsburgh; A. S. Aloe Company, St. Louis; Powers & Anderson, Richmond; Van Pelt & Brown, Richmond; and the Sport Mart, Charleston.

The golf committee has emphasized the fact that it will not be necessary for participants to furnish a handicap rating this year.

Play will be limited to afternoons on July 27, 28, and 29, and courses Nos. 1 and 3 will be used. Those who participate must notify the starter when play has begun, and play must be in threesomes or foursomes. Each participant will keep his own score.

Full information concerning the tournament may be obtained from Dr. R. R. Summers, of Charleston, chairman of the committee, Dr. Olin T. Coffield, of New Martinsville, and Dr. R. O. Halloran, of Charleston, members.

DOCTOR LAWRENCE HUNTINGTON SPEAKER

Dr. Joseph S. Lawrence, director of the Washington office of the American Medical Association, was the guest speaker at the spring luncheon of the Inter-Club Council, held at the Frederick Hotel in Huntington, May 22. The Council is composed of presidents and immediate past presidents of the women's organizations in that city.

Mrs. E. H. Greene, president of the Council, presided at the meeting, and Doctor Lawrence was introduced by Mrs. Gates Wayburn. His subject was, "The High Cost of Medical Care."

AM. BD. OB. AND GYN. EXAMINATION

The next scheduled examination by the American Board of Obstetrics and Gynecology (Part I) for all candidates will be held in various cities of the United States and Canada on Friday, February 2, 1951. Applications will be received until November 5, 1950. Application forms may be obtained by writing to Paul Titus, M. D., Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

TB AND HEALTH MEETING IN FALL

The annual meeting of the West Virginia Tuberculosis and Health Association will be held at the Hotel West Virginian, in Bluefield, September 20-21. Edmund P. "Bob" Wells, of Augusta, Maine, former executive secretary of the Association, will be the guest speaker at the banquet.

ACP IN ST. LOUIS IN 1951

The 32nd annual session of the American College of Physicians will be held in St. Louis, April 9-13, 1951.

CONVENTION SPEAKER HONORED

Dr. George M. Curtis, of Columbus, Ohio, who will be one of the guest speakers at the 83rd annual meeting of the West Virginia State Medical Association at White Sulphur Springs, July 27-29, was given the annual Iodine Award at the annual meeting of the American Pharmaceutical Association at Atlantic City, May 4, 1950.

The award consists of an honorarium of $1,000 and a citation reading "For distinguished research in the pharmacy and chemistry of iodine including fundamental physiologic and clinical investigations relating to the function of iodine in nutrition and its role in thyroid disease."

Doctor Curtis has been professor in the department of medicine and surgical research at Ohio State University since 1932 and has served as chairman of the department of research surgery since 1936.

AAUW FAVORS FOUR-YEAR SCHOOL

The West Virginia Division of the American Association of University Women has gone on record in Favor of the expansion of the present two-year school of medicine of West Virginia University to a four-year medical and dental school. This action was taken at the annual meeting at Jackson's Mill, May 20.

DOCTOR HOLROYD ON AMA AUXILIARY PROGRAM

Just before the West Virginia contingent left for the annual meeting of the American Medical Association in San Francisco, announcement was made by Mrs. Paul Craig, public relations chairman of the Woman"s Auxiliary to the American Medical Association, that Dr. Frank J. Holroyd, of Princeton, would be one of the speakers at a meeting of the AMA Auxiliary scheduled for Monday, June 26. He will discuss the methods used in West Virginia to obtain adoption of resolutions opposing compulsory health insurance by county, district, and state organizations.

VIRGINIAS SENIORS HONOR DOCTOR LAHEY

Dr. Frank H. Lahey, of Boston, has been elected to honorary membership in the Virginias Seniors Golf Association. Announcement of the election was made the first of June by the president, Dr. Gory Hogg, of Lewisburg.

Doctor Lahey, a former past president of the American Medical Association, will be one of the guest speakers at the 83rd annual meeting of the West Virginia State Medical Association at White Sulphur Springs, July 27-29. He will appear on the program on Saturday, July 29.

MEDICAL TENNIS TOURNAMENT

Doctors who expect to participate in the Medical Tennis Tournament at the Greenbrier during the annual meeting, July 27-29, are requested to write or call some member of the tennis committee, which is composed of Dr. S. L. Bivens, Charleston, chairman, and Drs. Robt. M. Biddle, Parkersburg, and John E. Lutz, Charleston. The grand championship trophy offered by Kloman Instrument Company, Charleston, and other valuable prizes will be awarded at the annual banquet, July 29.

FOUR-YEAR SCHOOL OF MEDICINE AND DENTISTRY RECOMMENDED FOR STATE

Separate reports prepared by Dr. Herman G. Weiskotten, Dean of Syracuse University College of Medicine, and Dr. Wilburt C. Davison, Dean of Duke University School of Medicine, concerning the advisability of constructing and maintaining a four-year school of medicine and dentistry in West Virginia were submitted to a legislative interm commttee and its advisory committee at a joint session held in the Senate Chamber, at the Capitol, in Charleston, June 7.

Senator W. Broughton Johnston, of Princeton, co-chairman with House speaker W. E. Flannery, presided at the meeting, and the reports were read by Dr. Clyde Colson, of Morgantown, the committee's secretary.

Both Doctor Weiskotten and Doctor Davison reported that a four-year school of medicine is needed and recommended that plans be made immediately for an overall building program.

The estimated cost of the entire building program outlined by the two deans will amount to from $6,000,000 to $10,000,000 depending upon location and use of possible available hospital facilities. It is estimated that the cost per annum of maintaining a school of medicine and dentistry would be approximately $750,000.

Both Drs. Weiskotten and Davison recommended that the school be built in Charleston, although Doctor Weiskotten qualified his recommendation by stating that the school should be located in Charleston "or an area of comparable size, population and accessibility which will better serve the interests of the state as a whole." It was suggested that, if it is not thought advisable to construct a four-year school at the present time, a two-year school should be built with the idea of expanding it into a four-year school when funds become available.

Budget Director D. L. Gainer told the group that West Virginia has no unencumbered surplus at the present time. He stated that he doubts whether any surplus will be left at the end of the present fiscal year. He further stated that the state would have little difficulty in providing funds for the maintenance of a four-year school when built, as the cost of such maintenance would be but about one per cent of the total state revenues.

The board of public works recommended to the 1949 legislature that the sum of $2,000,000 be appropriated for the proposed school, together with $1,900,000 for a hospital to be built in connection therewith. No action was taken by the legislature, and available funds in the surplus account were appropriated for other purposes.

Dr. Irvin W. Stewart, chairman of a sub-committee named by the interim committee to consider the possibility of obtaining federal funds for use in the construction and maintenance of a four-year school, reported that "material assistance on a matching basis might be available for a teaching hospital as a part of the federal hospital construction program."

It was not indicated at the meeting what recommendations will be made to the legislature by the

interim committee. It is probable that another meeting of the committee will be held early in the fall.

Dean Weiskotten's report, with the letter of transmittal, follows:

SYRACUSE UNIVERSITY

Syracuse, New York

College of Medicine
Office of the Dean

May 1, 1950

Senator W. Broughton Johnston
Senate of West Virginia
Charleston, West Virginia

Dear Senator Johnston:

Enclosed I am sending you a report of my recent visit to West Virginia. I am sure that many will consider the report as being too general. However, I have not considered it wise to attempt to go into too great detail at this time because of the uncertainty relating to many of the factors which may greatly influence your program. Furthermore, there are other factors which could not be accurately evaluated on the basis of my brief visit to your State. In my report, I have attempted to deal with fundamental principles and fundamental requirements which I believe to be sound.

I have not discussed any of the possible temporizing programs which may be proposed by interested groups. Frequently temporizing programs ultimately become dominant factors in subsequent developments to the detriment of originally planned sound programs.

I greatly appreciated the many courtesies shown me during my brief visit to your State. I personally and all members of the staff of the Council on Medical Education and Hospitals will be interested in being of any assistance possible in the formulation and execution of any program you may desire to initiate in the field of medical education.

Sincerely yours,

H. G. Weiskotten, Dean

HGW:B

REPORT OF VISIT TO WEST VIRGINIA

H. G. Weiskotten, M. D.

March 24 to 29, 1950

In order to clearly visualize the problem involved in connection with the proposal to establish a four-year medical school in the State of West Virginia, it is important to consider the present status of medical education in West Virginia and in the nation as a whole.

At the present time the State of West Virginia is conducting a two-year medical school (School of Basic Medical Sciences) as one of the colleges of the State University which is located in Morgantown, a community of approximately 16,000 population. The Medical School, located on the campus of the University, admits thirty-one students annually. The University has a contract with the Medical College of Virginia located in Richmond, Virginia, whereby the Medical College of Virginia admits twenty students annually from the two-year school into its third-year class that they may there complete their undergraduate medical education. The University of West Virginia pays the Medical College of Virginia $1,000 per student per year or a total of $40,000 per year. The remaining eight or ten students who each year satisfactorily complete the two-year course offered at the University of West Virginia individually seek admission to the third year classes of other medical schools.

The annual cost of the present program of medical education conducted by the University of West Virginia may be roughly estimated as follows:

Salaries	$145,000.00
Supplies and Equipment	25,000.00
Contract of Medical College of Virginia	40,000.00
	$210,000.00

This does not represent the total cost to the University as it does not include the cost of the upkeep of the buildings and grounds; heat, light and power; facilities for housing in other buildings of the University the departments of Biochemistry and Pathology as well as the Medical School Library; general university administration, purchasing, accounting, etc., as well as student privileges offered by the University. If prorated to the medical school by the University, these might well represent an addition of as much as $50,000 to the above mentioned cost of the conduct of the present medical school.

The present physical plant of the two-year school is entirely unsatisfactory and should be replaced at the earliest possible time if a satisfactory program for the first two-years of medical education is to be maintained. It should be made clear that this implies no criticism of the present medical school faculty, but rather of the physical facilities which are a serious handicap in the conduct of integrated teaching and research programs.

The Present Status of Medical Education in the Nation

Never before in the history of this country has medical education received the attention and interest of the public that is being accorded it today. Advances in medicine have made it possible for the well trained physicians to render to the public collectively and individually a type of service undreamed of a few years ago. Medical education has sought to keep pace with all of these advances and to train physicians who will be prepared to make all of them available in the prevention and treatment of disease. This has added greatly to the complexity and cost of medical education. To provide a student with the satisfactory foundation for the practice of modern medicine required ever increasing equipment and especially trained teachers.

Today more than one-half of the undergraduate curriculum in the medical schools is devoted to actual experiences with patients on the hospital wards and in out-patient clinics and the participation in the health and medical care programs of the community in which the school is located. At the same time, in recognition of the fact that most of the advances in medicine have their origin in the research programs of the medical schools, these programs are greatly expanded.

The integration of the teaching programs of medical schools into the health and medical care programs of their community have so improved the standards of these programs that affiliations with medical schools are frequently deemed essential to their satisfactory functioning.

Today, when possible, practically every new health and medical care program is planned to center in or in close affiliation with, a medical school.

The National Hospital Construction program, involving federal subsidy for the construction of new hospitals, plans for the direct or indirect affiliation of all hospitals with a medical school and its teaching hospitals—a medical center. This program in itself has stimulated states not now having a medical school to think seriously of the advisability of establishing one.

The Veterans Administration, recognizing the advantages of hospitals affliated with medical schools, have sought, in so far as is possible, to build all new Veterans Hospitals in intimate relationship with medical schools.

Another contribution of a medical school with its highly trained personnel and its teaching hospitals, is that it provides an opportunity for educational and service programs in a wide variety of highly specialized fields of medicine.

Furthermore, the rapid advances in medicine are creating increasing demands on the part of the physicians for post-graduate refresher courses. Hence, the medical profession of states not having medical schools are frequently interested in stimulating the development of new schools to provide such educational programs in addition to their other services.

All of these developments have greatly increased the responsibilities of the medical schools with a vast increase in their need for financial support. In fact, a number of the privately supported medical schools have frankly stated that unless more adequate financial support is forthcoming, it will be difficult for them to maintain present programs and impossible to proceed with planned developments. I know of no privately supported university not now having a medical school which would even consider the establishment of one.

The federal government has recognized the financial plight of the medical schools and during the past few years has been making categorical grants to them to improve the teaching in certain aspects of medicine which have seemed to be currently of great importance to the American public. Legislation has also been introduced to provide certain annual basic subsidy to medical schools.

In addition to the previously mentioned developments, there are other stimuli for the establishment of new medical schools, especially in states not now having schools. In the first place, there are many indications that there is need for an increased number of physicians beyond those the existing schools are in a position to train. There is a much greater number of young people who desire to undertake the study of medicine than there are opportunities in the existing medical schools. Furthermore, state supported medical schools are tending more and more to limit their students to residents of the state by which they are supported. Thus it frequently happens that the youth of states not having medical schools find it extremely difficult to secure an opportunity to undertake the study of medicine.

Without a four-year medical school integrated into a Medical Center with its hospitals, clinics and associated personnel, the State of West Virginia may ultimately be seriously handicapped in their medical and health service and educational programs.

The Cost

It is especially difficult at the present time to estimate how much it would cost the State of West Virginia to build and maintain a satisfactory four-year medical school and medical center. It is possible that federal funds may be available and will thus absorb a part of the cost of both construction and operation. Federal funds allotted to the State under the National Hospital Construction Program may provide 62% of the cost of construction of the teaching hospital and health center. The construction of a Veterans Administration General Hospital in intimate association with the medical school would assist materially in providing and maintaining a portion of the hospital beds which would be required for teaching. However, it must be recognized that future policies may alter the value of affiliations of medical schools with Veterans Administration Hospitals.

It is possible that federal legislation may be enacted which will provide some subsidy for actual operation of the medical school.

All of these possibilities of federal support and cooperation should be immediately explored through conferences with the United States Public Health Service and the Veterans Administration.

The over-all cost of construction of a satisfactory medical school building and a four hundred bed teaching hospital and out-patient clinics would probably be between eight and ten million dollars. The annual cost of operation of the four-year medical school should be estimated at approximately $750,000. The actual cost of the conduct of the teaching hospital would depend on many factors. The State Public Assistance Agency is this year spending $665,400.00 for the hospitalization of welfare patients in the general hospitals of the State on a per diem cost basis. How much would be available from this source to cover the cost of hospitalization in the teaching hospital of the medical school is uncertain. This possibility of contributing to the support of the teaching hospital should be explored. The income from private patients should also be considered in estimating the cost of operation of the teaching hospital.

The determination as to whether the State of West Virginia desires and can afford to develop and maintain a four-year medical school and its teaching hospital must be made by the State itself. Under any circumstances, it should not proceed with such a program until it is convinced that it will have available finances for its support.

Location

The ideal location for a medical school is on a general university campus in intimate relationship with the other colleges of a large university providing that in such a location all of the requirements for the satisfactory development and functioning of a high standard of medical education, medical research and medical service can be met.

Location on a general university campus offers opportunities for contacts and for cooperative programs which may be of increasing importance as time passes.

The successful development and operation of a four-year medical school depends in a large measure upon its location. Today more than one-half of the undergraduate curriculum of a medical school is integrated into the practice of medicine and the over-all health and medical care programs of the area in which it is located.

The Medical school and its hospital with its out-patient clinics should be so located as to be accessible for a natural flow of patients to the center for all types of medical service in both the out-patient clinics and on the hospitals wards. Thus the ideal location for a medical school is in a community which will readily provide a sufficient number and variety of patients on its hospital wards and in its out-patient clinics both for teaching and research. Furthermore, in such a location it is in a position to render its maximum contributions to the medical care program of the area in which it is located. In general, it is extremely difficult to provide adequate hospital and out-patient patients for satisfactory clinical instruction in a community of less than 200,000 population. The availability of the competent teachers in all of the various specialties of medicine which are essential to the conduct of a well rounded teaching, research and service program may also depend on the size and nature of the community in which the school is located.

The natural trend of hospitalization in the State of West Virginia has apparently been more toward the Charleston area than any of the other hospital areas of the State. The recent study of the hospitals of the State in connection with the National Hospital Construction program lists the number of general hospital beds in the various regions of the State as follows:

	Acceptable Beds	Non-Acceptable Beds	Total
Wheeling	612	118	730
Morgantown	200	9	209
Martinsburg	77	113	190
Huntington	779	464	1243
Bluefield	615	134	749
Charleston	955	461	1416

The location for a four-year medical school and its teaching hospitals in the State of West Virginia in order that it may best serve the interests of undergraduate and graduate medical education and the health and medical care programs of the State, is of the utmost importance.

It is my opinion that it would be unwise to attempt the development of the school in the Morgantown area. This opinion is based on the belief that:

(a) The area is not readily accessible to a sufficient population to provide adequate clinical material for teaching either in the out-patient clinics or on the hospital wards.

(b) The area is not readily accessible to a sufficient population to attract and hold the required competent clinical faculty in all of the various specialties of medicine, nor to contribute to their support through private consultation privileges.

(c) The area could not justifiably support the numerous community programs which are becoming an ever increasing part of medical education.

(d) Located in the Morgantown area the medical center could not serve the citizens of the State to the extent it could if more centrally located in a larger and more accessible community.

(e) The area is not readily accessible for the conduct of postgraduate refresher courses for the practicing physicians of the State.

Dentol Education

Although my experience in the field of Dental Education is very limited, I am convinced that much of the discussion of medical education applies equally to dental education. The need for clinical facilities, particularly out-patient clinics, is equally important. The need for an increased number of dentists equals and today probably exceeds, the need for physicians. Dental schools should be developed in intimate association with medical schools but should have their own faculties, whose first responsibilities are dental education.

Recommendotions

The State of West Virginia should, if possible, look forward to the ultimate development of a four-year medical school as an integral part of a Medical Center. The medical school should have unquestioned control of an adequate teaching hospital and out-patient clinic and health center. It should look forward to affiliation with other hospitals only if it has unquestioned control of the medical services used for teaching.

The medical school should be located in Charleston or an area of comparable size, population and accessibility which will better serve the interests of the State as a whole.

If the State is not prepared to develop a four-year medical school at this time, but looks forward to such a development in the future and wishes in the meantime to continue to conduct a school of basic medical sciences (a two-year medical school), it should endeavor to select the site for the ultimate development and rebuild its medical school on this site in such manner as it can best be integrated into the full development. The site selected should be of sufficient size as to provide for the full development of the Center as well as for its continued expansion. The site should be such as to provide opportunity for the future construction of a number of specialized hospitals and institutions as well as dormitories for medical, dental and nursing students as well as for house staff and other personnel.

The following report was submitted by Dean Davison:

DUKE UNIVERSITY
Durhom, North Corolina

School of Medicine
Office of the Dean

May 1, 1950

The Honorable W. Broughton Johnston
President of the Senate of West Virginia
Princeton, West Virginia

Dear Senator Johnston:

In response to your invitation under Senate Concurrent Resolution No. 9, I have had the pleasure of visiting Morgantown, Huntington and Charleston from 24 to 29 March, and offer the following observations concerning the advisability of the establishment of a four-year school of medicine, dentistry, and nursing of West Virginia University, the proper location of such a school, and the cost and adequate financing thereof:

1. Construction Costs

(a) A medical school building for 50 students to replace the present building for 30 students, regardless of whether it is for a two or four-year school and wherever it is built (see locations below), will cost approximately $2,500,000 (in addition to the land) if the construction is very basic and simple. Ootherwise an additional $500,000 to $1,000,000 will be needed.

(b) A 400-bed teaching hospital and a nurses' dormitory, whenever and wherever it is built, will cost approximately $6,000,000 (in addition to the land) for strictly utilitarian and functional construction. Otherwise an additional $1,000,000 will be required.

(c) A dental school and equipment would cost approximately $1,000,000.

2. Operoting Costs

(a) The present annual budget (in addition to tuition) for the two-year school for 30 students in a class at Morgantown is approximately $229,000 ($140,000 for instruction, $29,000 for supplies, equipment and library, $20,000 for heat, light, upkeep and other services from the University, and $40,000 as a subsidy to the Medical College of Virginia for 20 third-year and 20 fourth-year students at $1,000 each).

(b) The annual budget (in addition to tuition) for a two-year school for 50 students per class would cost approximately $450,000 ($300,000 for instruction, supplies, light, heat, etc., and $150,000 for subsidies to 4-year schools for 50 third-year and fifty fourth-year students at $1,500 each).

(c) The annual budget for a four-year school would be approximately $500,000 to $600,000 (in addition to tuition), and for the teaching hospital and school of nursing $250,000 to $350,000 (in addition to collections from patients), or a total of $750,000 to $950,000. In some schools, these costs are much higher (see Exhibits A and B).

(d) The annual operating costs of a dental school would be approximately $150,000 (in addition to tuition and collections from patients).

3. Lond for the Site

(a) At least 20 acres, and preferably 40 acres, should be secured wherever the two-year or four-year school is to be built. Eventually, the school will become a medical center with psychiatric, crippled children's, palsy, tuberculosis, Veterans and other special hospitals built on the site. At Morgantown, the County and University can furnish that amount of land free. At Huntington, 11 acres in connection with a proposed county hospital can be furnished and the balance of the 40 acres will cost approximately $500,000. At Charleston, the Charleston Memorial Hospital has 8 acres, and an additional 32 acres of land between McCorkle Avenue and the river, extending toward the Morris Harvey College, can be obtained for approximately $500,000.

4. Location of the School

(a) The advantages of Morgantown are the free site and the possibility of the close integration and association of the school with the other divisions of the University. However, the site cost of $500,000 at Huntington or Charleston would be less than ten per cent of the total cost of a four-year school and hospital, and the advantages of having a medical school on a university campus are theoretical rather than actual. Although the premedical, preclinical and clinical instruction should be closely integrated, the contact between the faculty of the academic basic sciences and that of the medical school is extremely limited, even when they are in adjacent buildings on the university campus. Unfortunately, in spite of the efforts of both groups to fraternize, misunderstanding and friction rather than mutual help are the usual results. The respective advantages of a campus and a city location for a medical school are described in Exhibits C and D.

(b) Huntington has at least two advantages: First, there are more specialists and potential medical teachers who would be available as part-time or geographic full-time faculty with less expense to the medical school than a strictly full-time faculty which would be needed by a school on a university campus in a small town (see Exhibits E and F). Second, there are more patients who can pay private and semi-private hospital rates, and thus carry a larger proportion of the hospital costs than usually is possible in a small university town. A city is especially needed for an adequate out-patient service as well as for obstetrics. The university clinics at Durham, Iowa City, Charlottesville, etc., suffer from too few acute and common conditions. Medical students should not be taught exclusively on the rarities of medicine. A large town is even more important for the dental clinic of the school of dentistry.

(c) Charleston, in addition to the two advantages possessed by Huntington, has two others. First, Charleston is nearer the center of population of the State and can serve a larger proportion of the people and medical profession (see Exhibit G). At Duke, less than 20 per cent of the patients come from the immediate area, and the balance from an average of over 75 miles. Therefore it is important that a medical school should be in the most accessible town. Second, the higher per capita wealth at Charleston will raise the hospital collections, as well as increase the possibility of gifts to the institution.

(d) Beckley, Bluefield, Clarksburg, Fairmont, Martinsburg, Moundsville, Parkersburg, Wheeling and other towns also were considered, but they did not have advantages comparable to those of Charleston (see Exhibits E and G).

5. Summary

(a) As early as possible, a site of at least forty acres should be selected for a four-year school of medicine, dentistry, and nursing, preferably at Charleston. The State eventually will have a four-year school because of the increasing need for medical, dental, and nursing care and personnel, and it should be planned now. Forty years ago, a medical school could be established by affiliation with existing city hospitals, enlisting the voluntary services of a few prominent practicing physicians in the community, employing a few faculty members to organize instruction in the basic medical sciences and constructing a building, often remote from the hospitals, for teaching laboratories and a small library. Today, the medical school is the basic unit of a medical center which has many functions and provides many public services. It is not an auxiliary unit of a city hospital. Students and faculties in medicine, dentistry, nursing, medical technology, medical social work, physiotherapy, and even occasional graduate students in the natural and social sciences are assembled under the same roof, learn to work together and stimulate each other. The state medical school and hospital should be the focal point in the organization of training programs for interns and residents. The role of the medical school in the continued education of practicing physicians is equally important.

(b) Every effort should be made to explore present and pending Federal and other aid to medical education and hospitals, and of the possibility that the Veterans Administration might build a general hospital near or on the site selected for a four-year medical school.

(c) A new medical building for fifty medical and fifty dental students per class is an immediate necessity due to the physical condition of the present school building at Morgantown. It should be stressed that this statement is no reflection on the quality of teaching now being done by the faculty. It is excellent and its high caliber is widely recognized. The new school should be built on the site selected, and if adequate funds are available for construction and operation, it should be designed and operated as a four-year school of medicine, dentistry, and nursing, and integrated with a teaching hospital and dental clinic.

(d) Although this report is concerned primarily with planning for a school of medicine, dentistry and nursing, it would not be complete without emphasizing the importance of providing facilities for training personnel for the related professions and auxiliary workers. Instruction of auxiliary personnel such as physiotherapists, medical laboratory technicians, medical social workers and dental hygienists may be introduced as the program develops by the addition of faculty members and increased appropriations but without further construction. Offices for the faculty, laboratories for clinical research and diagnosis and some classrooms should be incorporated in the hospital building in order to maintain close integration of teaching, research and service to patients. The school also should be so constructed that it can be expanded later to admit 100 students per class.

(e) If adequate funds for the building and operation of a four-year school are not available, and estimates of the State's revenue for the next few years indicate that these additional funds will be limited, the school still should be built on the site selected for a four-year school even though it is operated as a two-year school until funds for the operation of a four-year school are secured. Arrangements at $1,500 annually per student can be made with several four-year medical schools for the transfer of the 50 third-year and 50 fourth-year students.

(f) A two-year school of dentistry with affiliation with a four-year dental school elsewhere, similar to the present arrangement with the Medical College of Virginia is a possibility to be considered. Plans should be drawn so that this school building can be integrated with a teaching hospital and dental clinic when they become available.

(g) Keeping the school under the control of the Board of Governors of the University but omitting the name of the University in its title, and calling the school, "The Medical and Dental College of West Virginia," as is done in Georgia, Alabama and South Carolina, might cause less interference with appropriations to the University. It must be kept in mind that medical, dental and nursing education is expensive and that an excellent school will not thrive in the atmosphere of an inadequately financed system of higher education.

I wish to express my thanks for assistance in this report to Drs. Irwin Stewart, Edward J. Van Liere and Vernon W. Lippard, Prof. Clyde L. Colson, Mr. Charles Lively, and to you.

Yours sincerely,

Wilburt C. Davison

The following report was submitted by Dr. Irvin Stewart, president of West Virginia University, on behalf of himself and the sub-committee appointed by the interim committee to study the possibility of obtaining federal funds for the construction and maintenance of a four-year school in West Virginia:

WEST VIRGINIA UNIVERSITY
Morgantown

Office of the President

May 31, 1950

The Honorable
Broughton Johnston
Princeton, West Virginia

Dear Senator Johnston:

The committee which you appointed to consider the possibility of obtaining federal aid for the construction and operation of a four-year medical and dental school in West Virginia canvassed the various possibilities for such aid at a recent meeting in Charleston. There appear to be three possible sources which are reported upon separately below. Information with respect to items 1 and 2 was obtained by Dean Van Liere and with respect to item 3 by Dr. Dyer.

1. Veterans Administration Hospitals

On April 14, 1950, Dean Van Liere wrote Dr. Paul B. Magnuson, Chief Medical Director of the Veterans Administration, asking whether there might be funds available for the construction of a Veterans Hospital in the event that the present medical school be expanded into a four-year curriculum at a site to be chosen.

On April 21, 1950, Dr. Magnuson sent Dean Van Liere a reply of which the pertinent parts follow:

"I am very glad to have received your letter of April 14, 1950 relative to the possibility of providing a four-year medical school in West Virginia. It is my full intention to cooperate with and make use of the facilities of as many of the Class A medical schools of the country as possible. Only in this way can we fully carry out our basic function of providing good medical care to veterans."

"As you may know, the Executive Branch of the Government has placed a ceiling of approximately 131,000 beds on the total bed capacity of the Veterans Administration. All of the beds under this program have been planned for, and a very large proportion are now under construction."

"I cannot promise, therefore, that any additional construction will be planned for West Virginia."

It is clear that under the present circumstances we cannot expect federal aid from the above source. If, however, the Executive Branch of the Government should raise its ceiling in regard to the establishment of more beds for veterans, it is possible that West Virginia might share in this program.

2. Federal Aid to Medical and Dental Education (H. R. 5940)

There is a bill before the Congress which carries certain provisions for aid to medical and dental education for a period of five years. The main items in this bill which concern us are:

a. $500.00 for each regularly enrolled full-time medical student up to normal enrollment and $1,000.00 for each student in excess of normal enrollment.

b. $400.00 for each regularly enrolled full-time medical student up to normal enrollment and $800.00 for each student in excess of normal enrollment.

c. A total of $5,000,000.00 for aid in construction. Over 75 medical schools alone are eligible to participate in this program besides dental schools, osteopathic schools and others. The total amount received by an institution under these provisions may not exceed a stipulated percentage of the budget for medical and dental education. The bill carries a stipulation that a school participating in this program may not restrict its student body to bona fide residents of the state in which it was located.

The House Committee on Interstate and Foreign Commerce has announced that the full committee will meet on June 6 to consider H. R. 5940 in executive session. As nearly as can be ascertained at this date, H. R. 5940 is not likely to pass. Active opposition has developed from certain strongly organized groups.

If the bill should pass the Congress, the School of Medicine might receive considerable financial aid for training medical and dental students. The present policy of restricting our students to bona fide residents of the state, might have to be dropped as a condition to receiving aid. This step would require further study. At any rate, it will be of distinct interest to watch the progress of H. R. 5940.

3. Federal Aid to Hospital Construction

Dr. Dyer has furnished the following information:

"a. All federal funds allocated for hospital construction in West Virginia on July 1, 1947, and July 1, 1948, have been re-allocated. These allocations were made on the basis of thirty-three and one-third per cent federal and sixty-six and two-thirds per cent local matching funds.

"b. The July 1, 1949, State allocation amounting to $2,787,048.00 has not been encumbered, and will not be available on the basis of the increased federal participation of 62.29 per cent federal and 37.71 per cent local or State funds until July 1, 1950. This allocation must be re-allocated to State construction projects prior to July 1, 1951.

"c. On July 1, 1950, West Virginia will be eligible to receive the second allocation of $2,787,048.00, which will be available to the State for expenditure until July 1, 1952. Those two allocations will give us approximately five and one-half million dollars available on July 1, 1950, for hospital and related facility construction on a matching basis of 62.29 per cent federal and 37.71 per cent local community or State appropriated funds. The life of the entire program has been extended by Congress to July 1, 1955.

"d. The applications for federal funds from the high priority areas for community hospital construction must be processed beginning July 1, 1950, and at this time I have no way to determine how much these projects, if approved, will reduce our reserve of five and one-half million dollars.

"e. It seems at this time, that if the State Legislature should decide in January, 1951 to apply for federal funds to supplement any appropriation by the Legislature for a teaching hospital in connection with a State medical and dental school, that this application would take a high priority. If such an application should be made and approved, it would be on the basis of approximately 62.29 per cent federal and 37.71 per cent State appropriated funds. The amount of federal money available would depend upon the date of Part I of the application, and the amount of federal money remaining after prior high priority applications have been processed.

"f. In the event such a project should be approved for federal fund participation, it would include the total construction and equipment cost of a modern teaching hospital, but exclusive of the cost of the building site."

In summary, the situation appears to be (1) that we can expect no assistance from the Veterans hospital building program, (2) that material assistance on a matching basis might be available for a teaching hospital as a part of the federal hospital construction program, and (3) that there is no provision for federal aid for the construction of the teaching building or for any operating costs beyond that provided by H. R. 5940, which has very slim prospects of passage.

Respectfully submitted,

Irvin Stewart, for the committee consisting of Dr. N. H. Dyer, Dr. Donzio Lilly, Dr. E. J. Van Liere, Dr. Ward Wylie and Irvin Stewart.

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Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1949, Xanthine Derivatives, Philadelphia, J. B. Lippincott Company, 1949, p. 323.

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CONVENTION PROGRAM

83rd Annual Meeting

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS
July 27-29, 1950

WEDNESDAY AFTERNOON
July 26

3:00—Registration at Auditorium, The Greenbrier.

4:00—Pre-convention meeting of the Council. Thomas G. Reed, M. D., *presiding.*

THURSDAY MORNING
July 27

Presiding: Edward J. Van Liere, M. D.

9:00—Call to Order—Charles E. Watkins, M. D., President, West Virginia State Medical Association.

(The entire morning session will be devoted to a discussion of gastro-intestinal diseases. All of the speakers at this session are members of the faculty of the Medical College of Virginia, Richmond.)

Moderator: Kinloch Nelson, M. D., Professor of Clinical Medicine, Medical College of Virginia.

9:05—"The Treatment of Gastro-Intestinal Hemorrhage."—James O. Burke, M. D., Assistant Professor of Medicine.

The causes of gastro-intestinal hemorrhage are reviewed from the standpoint of incidence. The management of hemorrhage is discussed from the diagnostic points of history, examination and laboratory data. The use of early x-ray diagnosis is stressed.

Features of treatment of hemorrhage from esophageal varicies with the Rountree Bag and the use of early surgery in cases of massive hemorrhage from ulcer are presented.

Results of a recent series of about seventy-five cases of massive hemorrhage from ulcer are given. (Lantern Slides.)

9:45—"The Treatment of Benign Lesions of the Stomach and Duodenum."—Carrington Williams, M. D., Professor of Clinical Surgery.

In this discussion a number of benign lesions of the stomach and duodenum will be considered principally from the surgical viewpoint. It will include a few case reports illustrating the care of benign ulcer, diverticula, benign tumors, and hypertrophy.

10:30—Intermission.

10:40—Clinical Pathological Conference:

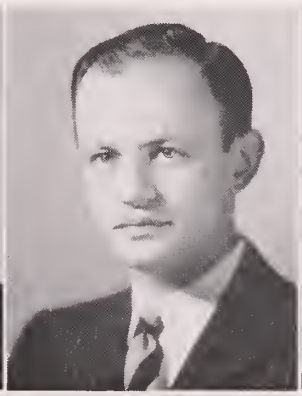
Presentation of Case—Charles M. Caravati, M. D., Assistant Professor of Clinical Medicine.

Presentation of Pathology—F. L. Apperly, M. D., Professor of Pathology. (Lantern Slides.)

11:40—Panel discussion of the papers presented by the speakers on the morning program.

CONVENTION SPEAKERS

Frank L. Apperly, M. D.



Allan C. Barnes, M. D.

Earl H. Baxter, M. D.

James O. Burke, M. D.

THURSDAY AFTERNOON

Meetings of sections and affiliated societies:

1:30—West Virginia Chapter of the American Academy of General Practice. Guest Speaker, Kinloch Nelson, M. D., Richmond, Virginia. Subject, "The Significance of Ascites." James L. Patterson, M. D., *presiding.*

1:30—Section on Orthopedic Surgery. Guest Speaker, Allen F. Voshell, M. D., Professor of Orthopedic Surgery, University of Maryland School of Medicine, Baltimore. Randolph L. Anderson, M. D., *presiding.*

2:00—Annual meeting of West Virginia Radiologists. V. L. Peterson, M. D., *presiding.*

3:30—Open Meeting, Auditorium. Guest speakers, Clem Whitaker and Miss Leone Baxter, members of the firm of Whitaker & Baxter, Chicago, in charge of the American Medical Association's National Education Campaign.
"The Broadening Front Against State Socialism."—Clem Whitaker.
"Medical Freedom—And How to Keep It."—Miss Leone Baxter.

4:30—First Meeting, House of Delegates.

5:30—Social Hour, Medical College of Virginia Alumni.

6:30—MCV Alumni Dinner. Guest speaker, Donald S. Daniel, M. D., Richmond, President, Alumni Association.

THURSDAY EVENING

Presiding: J. C. Huffman, M. D.

9:00—Presidential Address.—Charles E. Watkins, M. D.

Presentation of President's Charm.—Thomas G. Reed, M. D., Chairman of the Council.

Introduction of Mrs. Dana T. Moore, Parkersburg, President, Woman's Auxiliary to the West Virginia State Medical Association, and Mrs. Arthur A. Herold, Shreveport, Louisiana, President, Woman's Auxiliary to the American Medical Association.

FRIDAY MORNING
July 28

Moderator: Richard E. Flood, M. D.

9:00—"Modern Treatment of Thyroid Diseases."—George M. Curtis, M. D., Professor of Experimental Surgery, Ohio State University College of Medicine, Columbus. (Lantern Slides.)
(John C. Condry, M. D., will introduce the speaker.)

10:00—"The Use of Estrogenic Hormones in Clinical Practice."—Allan C. Barnes, M. D., Professor of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus.

At the present time the estrogens rank among the most misused of all the drugs in our therapeutic armamentarium, chiefly because of the current tendency to remember the list of conditions for which these hormones should be prescribed. Rather than review such a complex list, the present discussion centers around the principles which should underlie our endocrine therapy.

The use of the estrogens becomes more rational, and the therapeutic results are better, if the simple basic principles are remembered. (Lantern Slides.)

(Charles L. Goodhand, M. D., will introduce speaker.)

11:00—"Investigations with Cortisone and Related Hormones in Rheumatoid Arthritis and Related Diseases."—Howard F. Polley, M. D., Mayo Clinic, Rochester, Minnesota. (Lantern Slides.)

(Raphael J. Condry, M. D., will introduce the speaker.)

Note: A question and answer period will follow the presentation of each paper on the Friday morning program, with the Moderator in charge.

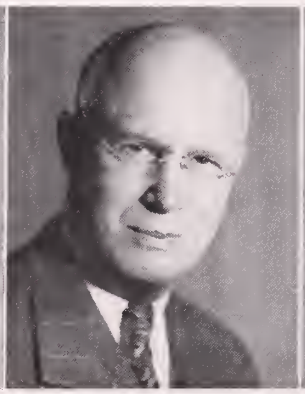
FRIDAY AFTERNOON

Meetings of sections and affiliated societies:

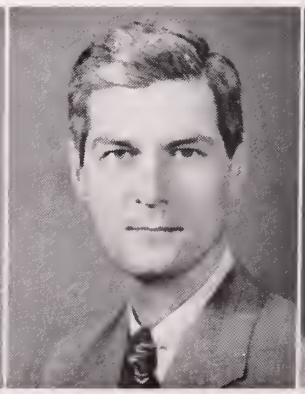
1:30—West Virginia Obstetrical and Gynecological Society. Guest Speaker, Allan C. Barnes, M. D., Columbus, Ohio. Subject, (A) "A New Approach to the Problems of Postpartum Hemorrhage," and (B) "The Covalt Isotope in the Treatment of Pelvic Malignancy." Roundtable discussion on pro-

CONVENTION SPEAKERS

Charles M. Caravati, M. D.



George M. Curtis, M. D.



A. William Friend, M. D.

Frank H. Lahey, M. D.

longed labor between papers "A" and "B". Charles L. Goodhand, M. D., *presiding.*

1:30—West Virginia Academy of Ophthalmology and Otolaryngology. Guest speaker, J. Morrisset Smith, M. D., New York City. Subject, "Endaural Operation for Chronic Mastoiditis." Charles T. St. Clair, M. D., *presiding.*

Technique of the Endaural Incision and approach to the Mastoid and Middle Ear.

The special value of the Endaural Operation in the preservation of the hearing and the management of cholesteatomas with small attic perforations.

The indications for the Modified and Radical Operations in Chronic Mastoid infections with a review of their techniques. (Lantern Slides.)

1:30—Association of Pathologists of West Virginia. Guest Speaker, F. L. Apperly, M. D., Richmond, Virginia. Marshall W. Sinclair, M. D., *presiding.*

1:30—Joint meeting, West Virginia Heart Association, Section on Internal Medicine, and the West Virginia Chapter of the American College of Physicians. Meeting in charge of John E. Stone, M. D., R. J. Condry, M. D., and Paul H. Revercomb, M. D.

Guest speakers: James O. Burke, M. D., Richmond, Virginia.—"The Diagnosis of Diseases of the Pancreas."

Pertinent facts of history, physical findings and laboratory data in acute pancreatitis, chronic recurrent pancreatitis, pancreatic lithiasis and cancer of the pancreas are presented. (Lantern Slides.)

Howard F. Polley, M. D., Rochester, Minnesota—"The Management of Acute Rheumatic Fever."

1:30—West Virginia Society of Anesthesiologists. Guest speaker, A. William Friend, M. D., Akron, Ohio.—"Present Problems and Concerns in the Practice of Anesthesiology." John F. Morris, M. D., *presiding.*

Observations on trends both scientific and economic will be presented. Voluntary prepaid medical and hospital care insurance plans and certain aspects of physician-hospital relationships will be discussed.

2:00—Section on Surgery. Panel discussion on "Surgical Treatment of Gastric Duodenal Ulcers."—George M. Curtis, M. D., Columbus, Ohio, and Carrington Williams, M. D., Richmond, Virginia. John C. Condry, M. D., *presiding.*

2:00—Section on Industrial Health. Guest speaker, Oscar B. Biern, M. D., F. A. C. P., Huntington—"The Occupational Disease Board and What It Does." Henry M. Brown, M. D., *presiding.*

3:30—Second meeting, House of Delegates.

FRIDAY EVENING

Presiding: Charles E. Watkins, M. D.

9:00—"The Activities of the American Medical Association."—Elmer L. Henderson, M. D., Louisville, Kentucky, President, American Medical Association.

SATURDAY MORNING
July 29

Moderator: James P. McMullen, M. D.

9:00—"The Acute Abdomen."—Philip Thorek, M. D., Chicago, Illinois.

Acute abdominal emergencies still continue to present one of the most vexing problems diagnostically and therapeutically with which the surgeon and general practitioner are confronted.

Following a fourteen year study, based upon clinical material, it was found that six outstanding conditions account for the greatest percentage of errors in the differential diagnosis of the acute abdomen. These are: (1) acute appendicitis, (2) acute cholecystitis, (3) perforated peptic ulcer, (4) renal colics, (5) acute hemorrhagic pancreatitis and (6) coronary occlusion.

These conditions are outlined and discussed and the pertinent facts pertaining to the various diagnostic signs and symptoms are evaluated.

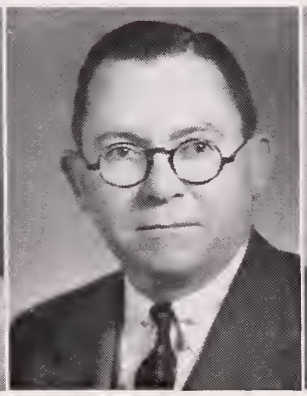
The roentgenogram as a diagnostic aid is thoroughly reviewed and the many pitfalls that one might encounter are stressed.

(T. Kerr Laird, M. D., will introduce the speaker.)

10:00—"The Newer Insulins."—H. B. Mulholland, M. D., Professor of Practice of Medicine, University

CONVENTION SPEAKERS

Henry B. Mulholland, M. D.



Kinloch Nelson, M. D.

Howard F. Polley, M. D.

of Virginia Department of Medicine, Charlottesville, Virginia.

Discussion of the principles underlying various types of insulin, preparations and use including insulin mixtures, globin insulin NPH-50. The problem of "brittle diabetes," insulin resistance, and the effects of insulin shots will also be presented. Experience with these various types of insulin over a period of several years. (Lantern Slides.)

(George P. Heffner, M. D., will introduce the speaker.)

11:00—"Common Respiratory Infections in Children."—Earl H. Baxter, M. D., Professor and Head, Department of Pediatrics, Ohio State University College of Medicine, Columbus, Ohio.

A classification of the common respiratory diseases is presented. The etiological factors are considered with emphasis on the individual variations of the child. An evaluation of the various therapeutic agents as sulfonamides, antibiotics, and antihistaminics is made. A regimen of general treatment of the acute diseases and for the prevention of recurrent diseases is discussed. (Lantern Slides.)

(Russell C. Bond, M. D., will introduce the speaker.)

12:00—"Lesions of the Terminal Ileum, Colon and Rectum."—Frank H. Lahey, M. D., Boston.

The paper on Lesions of the Terminal Ileum, Colon and Rectum will deal with one hundred and sixty cases of terminal ileitis. It will deal with the complications, the problem of multiple segments involved and our experience with recurrences after radical removal and what we have done to manage them. It will also deal with our experiences with seven hundred cases of ulcerative colitis, the complications which have required surgery and the results of ileostomy and total colectomy in these cases. It will also deal with the successful management of ileostomies and the rehabilitation of these patients.

This discussion will further deal with the malignant lesions of the colon and rectum, stressing particularly the relationships of polyps as a precancerous stage of malignancy of the colon and rectum, their early discovery and radical removal. It will discuss methods by which earlier diagnoses of cancer of the colon and rectum can be made and will present the five- and ten-year survival rate with radical removal together with the mortality figures.

(Thomas L. Harris, M. D., will introduce the speaker.)

Note: A question and answer period will follow the presentation of each paper on the Saturday morning program, with the Moderator in charge.

SATURDAY AFTERNOON

Meetings of sections and affiliated societies:

2:00—Section on Pediatrics. Roundtable discussion of "Pediatric Problems in General Practice," led by Earl H. Baxter, M. D., Columbus, Ohio. Russell C. Bond, M. D., *presiding.*

2:00—Section on Urology. Roundtable discussion and presentation of urological problems. Ray M. Bobbitt, M. D., *presiding.*

2:00—Organization meeting of West Virginia Diabetes Association. Guest speaker, Henry B. Mulholland, M. D., Charlottesville. Subject, "Benefits of State Professional and Lay Diabetes Associations." George P. Heffner, M. D., *presiding.*

SATURDAY EVENING

6:00—Cocktails, Spring Room. Host, Greenbrier Clinic.

7:00—Annual Banquet. Sobisca S. Hall, M. D., Clarksburg, Toastmaster. Feature attraction, Weirton Steel Male Chorus, Courtesy Weirton Steel Company.

Presentation of golf trophies.
Presentation of tennis trophies.
Presentation of Auxiliary trophies.

CONVENTION SPEAKERS

Philip Thorek, M. D.

Carrington Williams, M. D.

CONVENTION SPEAKERS

(Biographical Sketches)

FRANK L. APPERLY, M. D., Richmond, Virginia; born in Australia and educated at the Universities of Melbourne (D.Sc.), Oxford (M.A., M.D., B.Ch.), and Dublin; Rhodes Scholarship to Oxford, 1910; Captain, Royal Army Medical Corps, World War I, 1915-18; St. Thomas Hospital and Royal Northern Hospital, London, 1918-20; senior lecturer in Pathology, University of Melbourne, and physician to one of the University Hospitals in 1920-32; Fellow of the Royal College of Physicians, London; Professor of Pathology, Medical College of Virginia since 1932.

ALLAN C. BARNES, M. D., Columbus, Ohio; born at Coldwater, Michigan; Haverford School, Haverford, Pennsylvania; A. B., Princeton University, 1933; M. D., University of Pennsylvania School of Medicine, 1937; M. Sc., in Obstetrics and Gynecology, Univeristy of Michigan School of Medicine, 1940; Oxford Exchange Fellow in surgery at McGill University, 1937; instructor in Obstetrics and Gynecology at the University of Michigan, 1941; served as Major in the Army Medical Corps during World War II; member of the faculty at Ohio State University College of Medicine since 1945, and chairman of the Department of Obstetrics and Gynecology since 1947; diplomate of the American Board of Obstetrics and Gynecology; Fellow of the American College of Surgeons, and member of the Central Society for Clinical Research, and the American Federation for Clinical Research.

EARL H. BAXTER, M. D., Columbus, Ohio; Professor of Pediatrics and Chairman of the Department of Pediatrics, College of Medicine, Ohio State University; Chief of Staff of the Columbus Children's Hospital.

MISS LEONE BAXTER, Chicago, Illinois; General Manager, AMA National Education Campaign, and partner with Clem Whitaker in the public relations and campaign management firm of Whitaker & Baxter; born in the state of Washington; public school education in Oregon and Washington; majored in Economics, Stanford University; named Secretary-Manager of Redding (California) Chamber of Commerce at age 21, and in that capacity, directed development of first plans for California's Central Valley Water Project; entered into business partnership with Clem Whitaker in 1933, following work in newspaper and other writing fields, public relations and campaign management.

JAMES OTEY BURKE, M. D., Richmond, Virginia; Assistant Professor of Medicine and Chief of the Gastroenterology Clinic at the Medical College of Virginia, Richmond; Attending Physician at Medical College of Virginia Hospitals; Certified by the American Board of Internal Medicine and in Gastroenterology.

CHARLES M. CARAVATI, M. D., Richmond, Virginia; graduate Medical College of Virginia, 1922; Colonel, Medical Corps, AUS, World War I, serving as Chief of the Medical Services at Percy Jones General Hospital, Battle Creek, Michigan, and Woodrow Wilson General Hospital, Staunton, Virginia; now Associate Professor of Clinical Medicine at the Medical College of Virginia; Consultant in Medicine at the Veterans Administration Hospital, Richmond, and Governor of the Amercan College of Physicians for the state of Virginia.

GEORGE M. CURTIS, M. D., Columbus, Ohio; A. B. and A. M. in Biology, University of Michigan, 1910, and Ph. D., 1914; assistant professor of anatomy at Vanderbilt University Medical School, 1913-15, and head of the department, 1915-18; enlisted as a private in the Enlisted Medical Reserve Corps, World War I; M. D., Rush Medical College; elected to a Fellowship of the National Research Council following two years internship at the Presbyterian Hospital in Chicago; elected associate professor of surgery at the University of Chicago, 1925, and professor of surgery in 1932; professor in the department of medicine and surgical research, Ohio State University, 1932, and chairman of the department of research surgery since 1936.

Author of many papers relating iodine to the activity of the thyroid gland in health as well as in diesases; besides membership in the National Medical Societies, he was one of the founders of the Central Surgical Association, serving as secretary in 1940 and president in 1946.

A. WILLIAM FRIEND, M. D., Akron, Ohio; A. B. and M. D. (1929) Queen's University, Kingston, Ontario; practiced internal medicine in New York City, 1933-1940; member of the staffs of French and Postgraduate Hospitals during that time; resident in anesthesiology, Hartford Hospital, Hartford, Connecticut, 1940-1942; clinical assistant in anesthesiology, Hartford Hospital, 1942-1944; clinical assistant professor of anesthesiology, University of Minnesota Medical School, Minneapolis, Minnesota, 1944-1947; diplomate of the American Board of Anesthesiology, fellow of the American College of Anesthesiologists, fellow of the International College of Anesthetists, and vice chairman of the Board of Governors of the International Anesthesia Research Society; in private group practice of anesthesiology in Akron since January, 1948.

ELMER LEE HENDERSON, M. D., Louisville, Kentucky; born in Garnettsville, Kentucky; M. D., University of Louisville Medical School, 1909; has practiced specialty of General Surgery in Louisville since 1911; member of staffs of Kentucky Baptist Hospital and St. Joseph's Infirmary; served overseas with the Medical Corps of the Army during World War I, being released with the rank of Major; Lt. Col. in the Army Medical Reserve Corps, 1919-29; Special Surgical Consultant to the Air Surgeon's Office, United States Army, since 1942; Chairman of the Fifth Service Command Committee, Procurement and Assignment Service for Physicians, Dentists and Veterinarians, 1942-46; President, Kentucky State Medical Association, 1941-42; President, Southern Medical Association, 1946-47; Member Board of Trustees of the AMA, 1938-49, serving as Chairman, 1947-49; installed as President of the AMA in June, 1950; Delegate from the AMA to the World Medical Association in Geneva, Switzerland, 1948; named President-elect of World Medical Association in October 1949.

FRANK H. LAHEY, M. D., Boston; born at Haverhill, Massachusetts; A. B., Harvard College, 1900; M. D., Harvard Medical School, 1904; Professor of Surgery, Tufts College, 1913-17; Professor of Clinical Surgery, Harvard Medical School, 1923-24; now Director of the Lahey Clinic; Surgeon-in-chief to the New England

Baptist Hospital; Surgeon at the New England Deaconess Hospital and Trustee of New England University, Tufts College, New England Baptist Hospital, New England Deaconess Hospital, and National Fund for Medical Education; Past President of the New England Surgical Association; Past President of the American Medical Association; Honorary degree, D. Sc., Tufts College, 1927, Boston University, 1943, and Northwestern University, 1947; elected Honorary Fellow, Royal College of Surgeons of England, 1947, and awarded the Major-General Leonard Wood Award by the Boston City Hospital Alumni Association, 1950; Major, Army Medical Corps, AEF, World War I, being attached to Evacuation Hospital No. 30; National Chairman, Directing Board for Procurement and Assignment Service for the armed forces during World War II; Chairman of the Medical Consulting Board to the United States Navy; appointed by President Roosevelt in 1944 as Chairman for Revision of Physical Standards, and by President Truman in 1945 as a member of the Committee on Integration of Medical Services in the Government.

HENRY BEARDEN MULHOLLAND, M. D., Charlottesville, Virginia; born in Knoxville, Tennessee; educated in public schools in Knoxville, Washington, D. C., and Toronto, Canada; attended University of Toronto; M. D., University of Virginia Medical School, 1920; appointed Instructor in Medicine and Student Physician at the University of Virginia, 1922; Assistant Professor of Medicine, 1923; studied abroad in clinics in Germany, France, Denmark and England; returned to the University of Virginia as Associate Professor of Medicine and Assistant Dean of the University of Virginia Medical School; Chairman of the Virginia Council on Health and Medical Care, and Member of Council on Medical Service and the Committee on Rural Medical Service of the American Medical Association.

KINLOCH NELSON, M. D., Richmond, Virginia; born in Richmond; B. A., University of Virginia, 1923; M. D., University of Virginia Medical School, 1927; member of the medical staffs of McGuire Clinic and St. Luke's Hospital, 1929-37; practiced specialty of Internal Medicine in association with the late Dr. Clifford Beach, in Richmond, 1937-42; served as Major in the Medical Corps of the Army during World War II, in charge of the Chest Service of the 45th General Hospital at Camp Lee, Virginia; Rabat, French Morocco, and Naples, Italy, until 1944; appointed to faculty of Medical College of Virginia in 1945 as physician-in-charge of the Medical Out-Patent Department; at the present time, Professor of Clinical Medicine and Director of the Department of Continuation Education at the Medical College of Virginia.

HOWARD F. POLLEY, M. D., Rochester, Minnesota; born in Columbus, Ohio; A. B., Ohio Wesleyan College, and M. D., 1938, Ohio State University College of Medicine; M. Sc. in medicine, University of Minnesota Graduate School; appointed Fellow in Medicine at the Mayo Clinic in 1940; since 1942, Consultant in the Section on Rheumatic Diseases at the Mayo Clinic, except for years 1946-47 when he was Consultant in the Section on Physical Medicine; Assistant Professor in Medicine on the faculty of Graduate School at the University of Minnesota (Mayo Foundation); Associated with Doctors Hench, Kendall, and Slocumb in work on cortisone and ACTH for rheumatoid arthritis and related conditions.

JAMES MORRISSET SMITH, M. D., F. A. C. S., New York City; born in Pocahontas, Virginia; M. D., Medical College of Virginia, 1909; served as Lt. (j. g.) United States Navy, during World War I; author of Labyrinthine Surgery, 1922, Decompression of Facial Nerve for Facial Paralysis, 1931, the Radical Mastoid Operation, 1931, report of 425 Fenestration Operations for Otosclerosis, 1948, and many other articles; member American Otological Society, American Academy of Ophthalmology and Otolaryngology, and American Otological, Rhinological and Laryngological Society; Fellow, American College of Surgeons; attending Aural and Executive Surgeon, New York Eye and Ear Infirmary; consulting Otologist, Morristown Memorial, and St. Joseph's Hospitals; formerly Chairman School of Ophthalomology and Otolaryngology, New York Eye and Ear Infirmary; formerly Clinical Professor of Otolaryngology, Columbia University.

PHILIP THOREK, M. D., Chicago; Diplomate, American Board of Surgery; Fellow, American College of Surgeons; Member, American Association of Anatomists; Fellow, International College of Surgeons; Fellow, American Association of Chest Physicians; Clinical Assistant Professor of Surgery, University of Illinois; Associate Professor of Surgery, Cook County Graduate School of Medicine; Attending Surgeon, Cook County Hospital; Co-Surgeon in Chief, American Hospital; Senior Attending Surgeon, Alexian Brothers' Hospital.

CLEM WHITAKER, Chicago, Illinois; Director of the AMA National Education Campaign; partner with Miss Leone Baxter in the public relations and campaign management firm of Whitaker & Baxter; born in Arizona; attended public schools in California, and the College of Agriculture, University of California; served overseas in the Army during World War I; newspaper field, 1919-30, including city editorship of Sacramento (California) Union, and political writer for San Francisco Examiner; founder of newspaper syndicate which served 80 California newspapers, covering the State Capitol and Legislature; disposed of syndicate to United Press in 1930 and organized the first professional campaign management business in the United States, the firm of Campaigns, Inc., which Miss Baxter joined as a partner three years later; over 64 statewide political campaigns in California managed and directed, including the campaign of the California Medical Association against Governor Warren's Compulsory Health Insurance Program in 1945; co-publisher with Miss Baxter of California Feature Service, and co-owner and director with Miss Baxter of Campaigns, Inc., West Coast Campaign Management Firm.

CARRINGTON WILLIAMS, M. D., Richmond, Virginia; born in Richmond; A. B., University of Virginia; M. D., University of Virginia Medical School; professor of clnical surgery at the Medical College of Virginia, and on the staffs of Stuart Circle Hospital and the Hospital Division of the Medical College of Virginia; member of the Richmond Academy of Medicine, Medical Society of Virginia, American Medical Association, Southern Surgical Association, American Surgical Association, and Southern Society of Clinical Surgeons.

DELEGATES AND ALTERNATES

B-R-T (3)—Delegates, Donald R. Roberts, Elkins, Hu C. Myers, Philippi, and Guy H. Michael, Parsons. Alternates, Charles L. Leonard, Elkins, and John E. Lenox, Philippi.

BOONE (2)—Delegates, Ray I. Frame and H. A. Smith, Madison. Alternates, O. D. Ballard, Van, and Wyson Curry, Jr., Madison.

BROOKE (1)—Delegate, Ralph McGraw, Follansbee. Alternate, H. L. Hegner, Wellsburg.

CABELL (7)—Delegates, James A. Heckman, C. Stafford Clay, H. E. Beard, Clarence H. Boso, C. A. Hoffman, E. J. Humphrey, and I. I. Hirschman, Huntington. Alternates, J. J. Brandabur, John E. Stone, T. G. Folsom, F. L. Coffey, N. F. Hines, and R. M. Wylie, Huntington.

CENTRAL WEST VIRGINIA (3)—Delegates, Theresa O. Snaith, Weston, E. L. Fisher, Gassaway, and Eugene S. Brown, Summersville. Alternates, George D. Hill, Camden-on-Gauley, W. W. Huffman, Gassaway, and R. L. Chamberlain, Buckhannon.

DODDRIDGE (1)—Delegate, A. Poole, West Union.

EASTERN PANHANDLE (2)—Delegates, G. O. Martin and C. E. Power, Martinsburg. Alternates, A. W. Armentrout and E. Andrew Zepp, Martinsburg.

FAYETTE (3)—Delegates, R. DeWitt Peck and R. A. Updike, Montgomery, and J. N. Jarrett, Oak Hill. Alternates, T. Kerr Laird, Montgomery, and W. B. Davis, Rainelle.

GREENBRIER VALLEY (2)—Delegates, George L. Lemon, Lewisburg, and H. B. Strader, White Sulphur Springs. Alternate, James P. Baker, White Sulphur Springs.

HANCOCK (2)—Delegates, R. E. Flood and M. Bogarad, Weirton. Alternates, L. O. Schwartz and L. E. Yurko, Weirton.

HARRISON (4)—Delegates, L. D. Zinn, Sobisca S. Hall, C. O. Post, and James G. Ralston, Clarksburg. Alternates, T. V. Gocke, L. H. Mills, and H. V. Thomas, Clarksburg.

KANAWHA (11)—Delegates, Robert C. Bock, W. B. Rossman, P. A. Tuckwiller, G. F. Grisinger, V. L. Peterson, Richard O'Dell, H. M. Hills, Jr., R. R. Summers, Henry M. Escue, and C. B. Hall, Charleston, and H. H. Howell, Madison. Alternates, H. A. Swart, A. B. C. Ellison, F. A. Clark, Paul H. Revercomb, William C. Stewart, Marion Jarrett, William A. Thornhill, T. P. Mantz, R. A. Crawford, Jr., and J. T. Jarrett, Charleston, and J. T. Peters, South Charleston.

LOGAN (3)—Delegates, C. H. Hagan, Jr., Holden, Harold Van Hoose, Man, and E. H. Starcher, Logan. Alternates, A. M. French and Frank R. Jamison, Logan.

MARION (3)—Delegates, George T. Evans, E. W. Hickson, and S. W. Parks, Fairmont. Alternates, L. R. Lambert, F. F. Sowers, and Joe Yost, Fairmont.

MARSHALL (2)—Delegates, David L. Ealy and Harold B. Ashworth, Moundsville. Alternates, W. P. Bradford and J. C. Peck, Moundsville.

MASON (1)—Delegate, C. Leonard Brown, Pt. Pleasant. Alternate, Dan Glassman, Pt. Pleasant.

McDOWELL (4)—Delegates, Otis E. Linkous, Jr., Ray E. Burger, A. J. Villani, and H. T. Schiefelbein, Welch. Alternates, E. O. Gates, M. J. Murphy, and R. O. Gale, Welch, and E. D. Gibson, Iaeger.

MERCER (4)—Delegates, Frank J. Holroyd and L. J. Pace, Princeton, and Upshur Higginbotham and Hampton St. Clair, Bluefield. Alternates, C. I. Butt, Matoaka, S. G. Davidson, Bluefield, and Richmond Low, Princeton.

MINGO (2)—Delegates, E. T. Drake and W. W. Scott, Williamson. Alternates, L. F. Boland and W. S. Feldman, Williamson.

MONONGALIA (3)—Delegates, Maynard Pride, Eldon Tucker, and Keith Gerchow, Morgantown. Alternates, C. C. Romine and Robert Fleming, Morgantown.

OHIO (5)—Delegates, R. Alan Fawcett, D. E. Greeneltch, Robert J. Reed, Jr., George L. Vieweg, and W. M. Sheppe, Wheeling. Alternates, R. U. Drinkard, John H. Murphy, A. J. Niehaus, Francis J. Gaydosh, and James D. Bird, Wheeling.

PARKERSBURG ACADEMY (5)—Delegates, S. William Goff, Harold Ulch, James L. Wade, and Richard Corbitt, Parkersburg, and Richard Hamilton, St. Marys. Alternates, Logan W. Hovis, C. L. Goodhand, Athey R. Lutz, Dana T. Moore, and Paul L. McCuskey, Parkersburg.

POTOMAC VALLEY (2)—Delegates, Harry Coffman, Keyser, and V. L. Dyer, Petersburg. Alternates, J. B. Grove, Petersburg, and J. H. Wolverton, Jr., Piedmont.

PRESTON (2)—Delegates, H. C. Miller and B. B. Miller, Eglon. Alternates, H. H. Cashman, Hopemont, and D. P. Brown, Kingwood.

RALEIGH (4)—Delegates, Paul E. Vaughan, W. C. Covey, Doff D. Daniel, and W. Fred Richmond, Beckley. Alternates, G. C. Hedrick, T. U. Vermillion, and L. M. Halloran, Beckley, and John W. Whitlock, Affinity.

SUMMERS (1)—Delegate, D. W. Ritter, Hinton. Alternate, C. L. Howard, Hinton.

TAYLOR (1)—Delegate, Paul P. Warden, Grafton.

WETZEL (2)—Delegates, Terrell Coffield and T. B. Gordon, New Martinsville. Alternates, A. M. Dyer, Pine Grove, and E. C. Blum, New Martinsville.

WYOMING (1)—Delegate, J. F. Biggart, Mullens. Alternate, B. W. Steele, Mullens.

Casino-Country Club at the Greenbrier, showing the five fast-drying Har-Tru Tennis Courts, where tennis tournament will be played.

WOMAN'S AUXILIARY
to the
West Virginia State Medical Association

Official Program
26th Annual Meeting
The Greenbrier
White Sulphur Springs
July 27-29, 1950

THURSDAY AFTERNOON
July 27

12:00—Registration, Virginia Room.

4:00—Pre-convention meeting of the Board, Virginia Room. Mrs. Dana T. Moore, President, *presiding.*

THURSDAY EVENING

10:00—Bridge, dancing.

FRIDAY MORNING
July 28

8:00—Past President's Breakfast, private dining room. Mrs. W. E. Hoffman, *presiding.*

9:30—Formal opening of the Convention, Virginia Room. Mrs. Dana T. Moore, President, *presiding.*

Invocation—The Rev. Lloyd C. Courtney, D. D., Pastor Old Stone Church, Lewisburg.

Pledge of Loyalty—Mrs. A. M. French, Logan, President, Logan County Auxiliary.

Greetings—Dr. James P. Baker, Medical Director of the Greenbrier Clinic.

Response—Mrs. A. J. Villani, Welch, President, McDowell County Auxiliary.

Presentation of Convention Chairman—Mrs. R. H. Boice, Parkersburg.

Introductions—Mrs. Dana T. Moore.

Presentation of President Elect, Mrs. Ross P. Daniel.

Roll Call—Mrs. Seigle W. Parks, Fairmont.

Minutes of Pre-convention Board Meeting—Mrs. Seigle W. Parks.

Convention Rules of Order—Mrs. U. G. McClure, Charleston.

Credentials and Registration—Mrs. O. H. Brundage, Parkersburg.

Report of 1950 National Convention at San Francisco—Mrs. Ross P. Daniel.

Reports of Officers:
- President—Mrs. Dana T. Moore.
- President Elect—Mrs. Ross P. Daniel.
- First Vice President—Mrs. Charles L. Goodhand.
- Second Vice President—Mrs. R. H. Curry.
- Third Vice President—Mrs. W. E. Ackerman, Jr.
- Fourth Vice President—Mrs. J. P. Lilly.
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Welcome to New Auxiliaries—Mingo County Auxiliary and Taylor County Auxiliary. Presentation of Charters—Mrs. Ross P. Daniel.

FRIDAY AFTERNOON

1:00—Luncheon in honor of Past Presidents of the Woman's Auxiliary to the West Virginia State Medical Association; Dr. E. L. Henderson, President, American Medical Association; Mr. Clem Whitaker and Miss Leone Baxter, in charge of the AMA National Education Campaign; Mrs. W. E. Hoffman, 3rd Vice President, Woman's Auxiliary to American Medical Association; and presidents of the Ohio and Pennsylvania Auxiliaries. Mrs. S. William Goff, *presiding.*

Call to Order—Mrs. Dana T. Moore, President.

Invocation—Mrs. Herbert Beddow.

Guests—Drs. Paul L. McCuskey, William A. Thornhill, Jr., Frank J. Holroyd, Elizabeth McFetridge, and E. H. Starcher, members of the State Advisory Board; and Dr. C. E. Watkins, President of the West Virginia State Medical Association, Mrs. C. E. Watkins, and Mrs. E. L. Henderson.

3:00—Card games, golf, tennis, swimming, horseback riding.

FRIDAY EVENING

10:00—Dancing, bridge, Canasta.

SATURDAY MORNING
July 29

9:30—General Session, Virginia Room. Mrs. Dana T. Moore, *presiding.*
Minutes—Mrs. Seigle W. Parks.
Announcements—Mrs. R. H. Boice.
Credentials and Registration—Mrs. O. H. Brundage.
In Memoriam—Mrs. F. Carl Chandler.
Resolutions—Mrs. O. H. Brundage.
Reports of County Presidents:
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Raleigh—Mrs. Ross P. Daniel.
Wood—Mrs. M. A. Santer.
Unfinished Business.
New Business.
Report of Nominating Committee—Mrs. W. E. Hoffman.
Election of Officers.
Installation of Officers and Presentation of President's Pin—Mrs. Arthur A. Herold, President of the Woman's Auxiliary to the American Medical Association.
Inaugural Address—Mrs. Ross P. Daniel, Beckley.
Courtesy Resolutions.
Adjournment.

SATURDAY AFTERNOON

1:00—Luncheon in honor of Mrs. Arthur A. Herold, Shreveport, Louisiana, President of the Woman's Auxiliary to the American Medical Association, and Mrs. Ross P. Daniel, Beckley, President of the Woman's Auxiliary to the West Virginia State Medical Association. Mrs. Charles L. Goodhand, *presiding.*
Call to Order—Mrs. Dana T. Moore.
Invocation—Mrs. U. G. McClure.
Guest Speaker, Mrs. Arthur A. Herold.
Guests—Presidents of the Ohio and Pennsylvania Auxiliaries.

3:00—Post-convention Board Meeting, Virginia Room. Mrs. Ross P. Daniel, *presiding.*
School of Instruction for Officers and Chairmen.

SATURDAY EVENING

6:00—Cocktails, Spring Room. Host, Greenbrier Clinic.

7:00—Annual Banquet.

10:00—Dancing.

THE FBI WILL GIT YOU EF YOU DON'T WATCH OUT

(From James Whitcomb Riley's "Little Orphant Annie")

The poem, "The FBI Will Git You Ef You Don't Watch Out," by Tom Hendricks, Secretary of the AMA Council on Medical Service, was first published in the fall of 1949. It is being reproduced at the request of several members of the Barbour-Randolph-Tucker Medical Society. Mr. Hendricks was the guest speaker at a banquet sponsored jointly by the Society and the West Virginia Chapter of the American Academy of General Practitioners, at Elkins, June 15, 1950. The poem follows:

J. Edgar Hoover's come to A.M.A. to stay
An' scrutinize our records an' cause us all dismay,
An' probe into our papers an' snoop around a heap
An' analyze our every thought an' the company we keep.
An' all us bad "monopolists" when suppertime is done
We set around the radio an' has the mostest fun
A-listnin' to the witch-tales 'at McGrath tells about
How the F.B.I. will git you
Ef You . . . Don't . . . Watch . . . Out.
Wunst there wuz a doctor who wouldn't say his prayers.
Fer Bess an' Marg an' Harry an' all the White House heirs.
The nurses heerd him holler an' his patients heerd him bawl
An' when they wint and looked fer him, he wuzn't there at all.
They put 'im in the deep-freeze safe from freedom of the press
An' went through all his tax returns from '38, I guess.
An' all they ever left him wuz his pants turned round-about
An' the F.B.I. will git you
Ef You . . . Don't . . . Watch . . . Out.
An' once there wuz a dentist who'd allus scoff an' sneer
An' say that social dentistry would *never* happen here.
He defied the British Empire, Mister Bevin's social state.
An' vowed his Yankee brothers would not share that tragic fate—
An' his awful blasphemies made blue the office air
He turned an' saw two G-men a-standin' by his chair;
They quickly checked his records 'fore he knew what he's about—
An' the F.B.I. will git you
Ef You . . . Don't . . . Watch . . . Out.
So allus make your night calls though the bills are overdue
An' your bed is soft an' comfy an' the wind goes woo-oo.
You can hear Jack Ewing rantin', you can hear Mike Davis bray
An' Falk a-spoofin' Congress that folks won't have to pay—
So you'd better watch your patients an' mind your P's and Q's,
Attend your county meetin's an' pay up your annual dues
An' warn your friends an' neighbors ef the doctors take the count
How the F.B.I. will git *them*
Ef They . . . Don't . . . Watch . . . Out.

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OBITUARIES

HERBERT BENNETTE WISE, M. D.

Dr. Herbert Bennette Wise, 46, of Weston, died in a hospital in that city, June 9. He had been in a critical condition for several months following a stroke suffered late in 1949.

Doctor Wise was born in Charleston and received his early education in the schools in that city. He was a graduate of Charleston High School. He received his A. B. degree from West Virginia University in 1928 and his M. D. degree from Temple University School of Medicine, in 1932.

After practicing in Grantsville for several years, he returned to Charleston in 1942, where he served as city health officer until 1946.

He was named health officer of District No. 4 in 1947 and was stationed at Weston. He resigned this office in September, 1949, because of ill health.

Doctor Wise was an honorary member of the Central West Virginia Medical Society, the State Medical Association, and the American Medical Association.

Besides his widow, he is survived by a daughter, Mary Frances, of Weston, a brother, Dr. Carl R. Wise, of New York City, a sister, Mrs. T. J. Jacquet, of Charleston, and his mother, Mrs. B. A. Wise, also of Charleston.

MARY M. ROBERTS FELLOWSHIP FOR NURSES

The board of directors of the American Journal of Nursing Company has announced the establishment of the Mary M. Roberts' Fellowship, the purpose of which is "to assist a qualified professional nurse to prepare herself in the technical aspects of writing about nursing and nursing education for professional and lay publications."

The criteria for making the award will be the general professional qualifications of the candidate and her interest and facility in writing. One of the requirements for candidacy will be a specially prepared manuscript on some subject pertaining to nursing. The award, which will be made late in the summer of 1950, will provide a sum of $2,500 to $4,000, the exact amount to be determined by the Award Committee, for one academic year of study in a college or university.

Nurses who wish to qualify for this award may obtain the necessary application blank by writing to "Fellowship," American Journal of Nursing, 1790 Broadway, New York 19, New York.

RELAXATION NOT INDICATED

We should not be lulled into peaceful relaxation in the belief that the administration's socialized medicine plans have been killed. Remember, it is the wounded bear that kills the hunter.—Haddon Peck, M. D., in J. Kansas Med. Soc.

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COUNTY SOCIETIES

CABELL

Mr. Harold L. Herbert, of the Physicians and Dentists Business Bureau, of Huntington, was the guest speaker at a meeting of the Cabell County Medical Society, held May 11, at the Hotel Frederick in that city. Mr. Herbert discussed the use of what he termed "an interesting device" in the campaign that is now being waged against compulsory health insurance.

A three-minute timing device, hour-glass in shape, which has been distributed by the Michigan State Medical Society to doctors throughout that state, was described by the speaker. He stated that it is kept on the desk in the consultation room of members of the society. "When a patient enters the room," he said, "the doctor upends the hour-glass without offering any explanation of his action. After approximately three minutes the sand has run through the glass and the consultation usually has just begun. At this point, the doctor explains to the patient that if he or she had been in England, or had we socialized medicine here, his, the patient's visit, would have been over." The speaker said that the point is made that while we like three-minute eggs here in the United States, we will never be satisfied with three-minute medical care.

Another application of the plan discussed by the speaker is to show that socialized medicine in the United States, based upon an estimate of approximately 15 billion dollars per year, would cost $90,000 for the period it takes the sand to run through the timer.

The speaker offered to supply each member of the Cabell County Medical Society with one of the timers for use in his office.

Dr. C. E. Watkins, president of the West Virginia State Medical Association, and Charles Lively, executive secretary, were guest speakers at the meeting of the Cabell County Medical Society, held June 8. at the Frederick Hotel in Huntington, at 8:30 P. M.

Doctor Watkins discussed pending and proposed amendments to the Association's constitution and by-laws, urging the members of the society to study the proposals before the annual meeting at White Sulphur Springs, July 27-29. He discussed the work that is being done by various committees and presented a preview of matters that will be taken up for consideration at the annual meeting of the House of Delegates.

Mr. Lively discussed administrative matters of the Association and gave a breakdown of the present membership by component societies. He stated that the membership is at an all-time high, and that over 93 per cent of the members have already paid AMA dues for 1950. He also discussed the program that has

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been prepared for the annual meeting at the Greenbrier, and gave a short report of the status of pending legislation in Congress.—James A. Heckman, M.D., Secretary.

* * * *

FORT HENRY ACADEMY

At a meeting of the Fort Henry Academy of Medicine, held at the Wheeling Country Club, May 25, 1950, Dr. Edward V. Arbaugh, Jr., of Martins Ferry, Ohio, was elected president. He succeeds Dr. D. E. Greeneltch, of Wheeling.

Other officers were elected as follows: Vice president, J. D. Bird; secretary-treasurer, R. U. Drinkard; program chairman, C. D. Hershey; and program chairman elect, J. S. Gaynor.

Dr. Elmer L. Henderson, of Louisville, president elect of the American Medical Association, was the guest speaker. He spoke most interestingly concerning the work of the parent organization, stressing particularly the success to this date of the National Education campaign. He praised the efforts of Whitaker and Baxter, and called for full cooperation on the part of all of the doctors of America.

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The meeting was attended by guests from several component societies in West Virginia, and from nearby societies in Ohio and Pennsylvania. Dr. C. E. Watkins, of Oak Hill, and Charles Lively, of Charleston, attended the meeting as representatives of the West Virginia State Medical Association.—Robert M. Sonneborn, M.D., Secretary.

* * * *

KANAWHA

Captain J. M. Brewster (MC), U.S.N., was the guest speaker at the regular monthly meeting of Kanawha Medical Society, held June 13, at the Daniel Boone Hotel, in Charleston. His subject was, "The Alarm Reaction—Its Relation to Origin and Antihistamine Therapy of the Common Cold."

Captain Brewster, who has done considerable work with antihistamines in the prevention of the common cold, participated in the panel discussion of the subject at the annual meeting of the American College of Physicians in April, 1950. He has written several papers on the subject, and has been widely quoted in medical journals over the country.

Captain Brewster, formerly of Weston, has served in the medical corps of the Navy for the past 27 years. He had his first two years in medicine at West Virginia University, graduating in 1921. He received his M.D. degree at Jefferson in 1923, and began his internship in the Navy that same year.

At the present time, he is a member of the Physical Evaluation Board, 4th Naval Hospital, in Philadelphia.

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At the business meeting following the scientific program, Dr. Ernest Q. Hull, of Charleston, was elected to membership, and Dr. Robert E. Gibson, also of that city, was accepted as a member by transfer from the McDowell County Medical Society.—Robert C. Bock, M.D., Secretary.

* * * *

MINGO

At the regular monthly dinner meeting of the Mingo County Medical Society, held June 14, at the Williamson Memorial Hospital, the by-laws were amended to increase annual dues from $2.00 to $10.00 per annum. The secretary was directed to have the constitution and by-laws printed and distributed to all members.

Dr. J. E. Johnson was named chairman of the public relations committee, and the other members are Drs. E. T. Drake and L. F. Boland.—E. T. Drake, M.D., Secretary.

* * * *

POTOMAC VALLEY

Dr. C. E. Watkins, president of the West Virginia State Medical Association, and Charles Lively, executive secretary, were guest speakers at the regular monthly dinner meeting of the Potomac Valley Medical Society, held at the Hermitage, in Petersburg, June 14.

Doctor Watkins discussed the problems of medical care in West Virginia, stressing the great need for a four-year school of medicine and dentistry. Mr. Lively discussed pending and proposed legislation, both state and national.

At the business meeting preceding the scientific program, Dr. V. L. Dyer, of Petersburg, was elected Delegate to the House of Delegates, and he will serve with Dr. Harry Coffman, the secretary. Dr. J. B. Grove, of Petersburg, and Dr. J. H. Wolverton, Jr., of Piedmont, were elected alternates.—Harry F. Coffman, M.D., Secretary.

DOCTORS SERVING RESIDENCIES

Dr. Walter E. Bundy, Jr., of Oak Hill, has accepted a residency in pediatrics at the Medical College of Virginia Hospital, in Richmond. His home address there is 3436 Keighly Road.

Dr. James C. Quick, of Clendenin, has accepted a residency in surgery under Dr. Guy Horsley, Jr., at St. Elizabeth's hospital, 617 West Grace Street, Richmond, Virginia.

NEED FOR CRUSADING CITIZENS

The national campaign of education of the American Medical Association will depend for its success upon the doctor becoming, of his own free will, an alert, crusading citizen—teaching the evil and false doctrine of federal compulsory health insurance.

Let us not make the mistake that England did—negativism and poor public relations. The English got the impression that the medical profession opposed State Socialized Medicine for selfish financial reasons. The consequences are now well demonstrated. Full cooperation and demonstration of willingness to effect superior service at the level of large national accounts may save our country from a similar catastrophe.—N. Y. Medicine.

BOOK REVIEWS

MEDICAL GYNECOLOGY—By James C. Janney, M. D., F. A. C. S., Associate Professor of Gynecology, Boston University School of Medicine; Associate Visiting Gynecologist, Massachusetts Memorial Hospital. New, Second Edition. Pp. 454, with 108 figures. Philadelphia and London: W. B. Saunders Company. 1950. Price $6.50.

"Medical Gynecology" is a new type of textbook and may also serve as a good review for the general practitioner. Uniquely, the author shows the importance of individual diagnosis in relation to the patient's symptoms and in correlation with physiologic and pathologic considerations, as gleaned from twenty-five years of didactic teaching.

The first section deals with classifying the patient's condition after a detailed history and general physical examination have been completed. The history is basically an elaboration of the patient's chief complaints, and these usual gynecological conditions are then listed and discussed. Following this chapter, are the physical findings associated with such complaints. Then all of the usual laboratory tests are surveyed, with emphasis placed on which tests are of help in diagnosis of each case. Such innovations as culdoscopy, the Papanicolaou smear, and newer pregnancy tests are included. Successively, the various forms of office gynecological therapy are reviewed, along with the newer aspects of endocrine treatment. There is even a chapter on "Corsets."

Because fundamentally the book concerns itself chiefly with the patient's problems, many important and usually text-omitted subjects are presented, such as "Emotional, Economic and Social Factors," "Preparation for Marriage," and "Marital Maladjustment."

Then, for the sake of completion, the final chapter of "Medical Gynecology" is entitled "Irradiation or Operation," in attempt to define what cases are best relegated to surgery, especially regarding uterine bleeding and cancer.

It is interesting to note that Dr. Janney favors the alkaline rather than the widely used acid douche. He logically states that "raw or ulcerated surfaces heal better in an alkaline medium, and when health is restored, the usual vaginal acidity automatically returns."

Especially in a book primarily intended for the student and the general practitioner, advice is wisely given regarding the danger of relying too much on the Papanicolaou smear for cancer. He points out the unreliability of a negative smear and mentions the paucity of pathologists well-trained in this field.

In league with the idea that such numerous forms of therapy for trichomonas vaginitis bespeak lack of any good treatment for this common disease, Dr. Janney is loath to discard the old 25 per cent sodium chloride douche for more agreeable treatment, such as the vinegar water douche, Negatan, Nylmerate Jelly,

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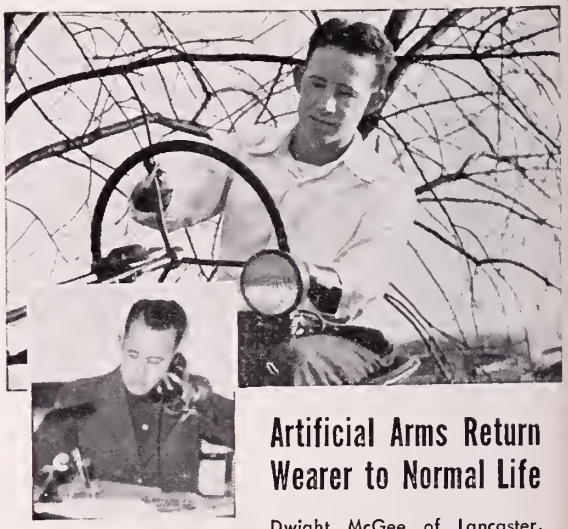

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or the more recently tried Aueromycin used locally. He mentions the rectum as a source of re-infection, but fails to note that the disease is often contracted from not flushing public toilets before use; also, that there may be many additional sources of recurrence, such as Skene's glands, the urinary bladder, occasionally the Bartholin glands, and not rarely the husband. A text in office gynecology is not complete without including these facts and adequate methods of cure.

Related also is the subject of topical anesthesia. The vagina is extremely tender in any severe infection, and application of a 2 per cent Butyn Sulfate solution for about five minutes will give appreciated relief in beginning treatment. Butyn solution is also of benefit when it is necessary to coagulate Skene's glands, to remove urethral caruncles, to cauterize the cervix, or to dilate or examine through a virginal introitus. The author does mention use of cocaine, but fails to warn of the possible lurking danger of sensitivity to this drug.

In all gynecology probably the most controversial subject is endocrine therapy. Little has been done to increase our knowledge in this field during the past several years and truths have been learned largely through experience, sometimes harmful. One interesting and important observation noted by the author of "Medical Gynecology" is that the cheaper estrogens, such as Stilbestrol, are more likely to cause post-menopausal vaginal bleeding than are the more expensive "natural estrogens."

As a whole, "Medical Gynecology" is an excellent text for the student and would be a valuable addition to the library of any physician who must treat gynecological conditions.—H. Edna Myers Jeffreys, M.D.

* * * *

SEXUAL DEVIATIONS—By Louis S. London, M. D., and Frank S. Caprio, M. D. Pp. 702. The Linacre Press, Inc., Washington, D. C. 1950. Price $10.00.

It is the avowed purpose of the authors of this book to produce a comprehensive reference work based on current material to bring up to date the science of sexual psychopathology, as founded by Havelock Ellis, Kraft-Ebing, and others. They fall somewhat short of this goal, as they admit. In a book as relatively short as this, the task would be impossible, but this volume contains much valuable material.

The method of presentation is by case histories, and all deviations which are extensively discussed are illustrated by cases from the authors' own practices. Theoretical considerations are given a minimum of space. Many conditions are dismissed with a paragraph or two (i. e., nymphomania, satyriasis, autoeroticism), while others are treated at great length. The approach is entirely psychoanalytical, with emphasis on dreams and their interpretation. In one section, 114 pages are devoted to the analysis by one of the authors of a female homosexual from her dreams and free associations alone, without him having seen the patient. The use of so much space for this *tour de force* seems unwarranted.

The authors insist that homosexuality is always an acquired sexual neurosis, and therefore curable by

psychoanalysis. If this be true, a rather formidable challenge to psychiatry is presented.

The book is well written in an easy, highly readable style, and on the whole is an important contribution to psychiatric literature.—David W. Northup, Ph. D.

* * * *

THE CYTOLOGIC DIAGNOSIS OF CANCER—By The Staff of the Vincent Memorial Laboratory of the Vincent Memorial Hospital, Boston, Massachusetts. Published under the Sponsorship of the American Cancer Society. Pp. 229, with 153 figures. Philadelphia and London: W. B. Saunders Company. 1950. Price $6.50.

Without a question of doubt, this is the most complete treatise on the subject that has been published to date. The descriptions are terse yet complete; illustrations are well done. Such a book should be helpful to anyone interested in this type of work. It is fitting that this book should be dedicated to Dr. George N. Papanicolaou, who has pioneered and contributed so much to the subject.—M. L. Hobbs, M.D.

* * * *

UROLOGICAL SURGERY—By Austin Ingram Dodson, M. D., F. A. C. S., Professor of Urology, Medical College of Virginia, Richmond. Second Edition. Pp. 855, with 645 illustrations. The C. V. Mosby Company, St. Louis. 1950. Price $13.50.

Almost from its appearance six years ago, Dodson's Urological Surgery achieved such widespread acclaim that the publication of a second edition calls for little other than notation of changes. As in the first edition, the author sticks to his objective of describing urological operations while giving adequate attention to diagnostic procedures and pre- and post-operative care. The author's work has been supplemented by contributions of several others, among which Prather's on injuries to the urinary organs and Howard's on renal tuberculosis are outstanding.

The more recent trends in use of antibiotics, retropubic prostatectomy, and the greater stress on radical surgery in malignant diseases of the prostate and bladder are all brought into proper relation with the balance of the work. The illustrations, again by Miss Helen Lorraine, which have been increased to six hundred and forty-five, are excellent. This book is a must in any well rounded medical library.—G. G. I.

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5 June 1950

Mr. Charles Lively
Executive Secretary
West Virginia State Medical Association
302 Atlas Building
Charleston, West Virginia

My dear Mr. Lively:

To keep military reserve medical officers of the Armed Forces, Army, Navy and Air Force posted on the latest developments in the field of medical science, a Medico-Military Symposium for officers of the Fourth Naval District will be held at the U. S. Naval Hospital, Philadelphia, Pa., from October 23 to 28.

Commodore Richard A. Kern, MCR, USNR, Professor of Medicine, Temple University School of Medicine, and chairman of the symposium general committee, has announced that Rear Admiral Clifford A. Swanson, MC, USN, Surgeon General of the Navy, will open the meetings with an address on "The Physician as a Naval Officer."

Officers attending the symposium will be welcomed by Rear Admiral Roscoe E. Schuirmann, Commandant of the Fourth Naval District; Brigadier General Leonard E. Rea, USMC; Captain Clyde W. Brunson, MC, USN, Commanding Officer of the Philadelphia Naval Hospital; and Captain J. R. Thomas, Fourth Naval District Medical Officer.

Speeches and panel discussions are scheduled in aviation medicine, national defense in case of disaster or attack, national preparedness, psychiatry, submarine medicine, surgery and orthopedics. Physicians selected to head the panels include Big. Gen. James P. Cooney, Chief, Radiology Branch, Division of Military Aplication, Atomic Energy Commission; Dr. Perrin Long, Professor of Medicine, John Hopkins University; Captain John Poppen, MC, USN; Captain George Lyons, MC, USN; Rear Admiral C. J. Brown, MC, USN; Captain C. W. Shilling, MC, USN; Dr. Frank Braceland; Dr. Joseph Hughes, Dr. Edward Strecker and Dr. Christian J. Lamberton.

It is urged that officers make hotel reservations well in advance, since no government housing facilities will be available. The final session of the symposium will be held Saturday morning, October 28, leaving the afternoon free for officers to attend the Penn-Navy football game.

The attendance at this symposium is not restricted to Medical Officers of the Armed Forces. All members of the Medical profession are cordially invited to attend.

Sincerely yours,
M. H. Porterfield
Commander, MCR, USNR
Assistant to District Medical Officer
Naval Medical Reserve Program

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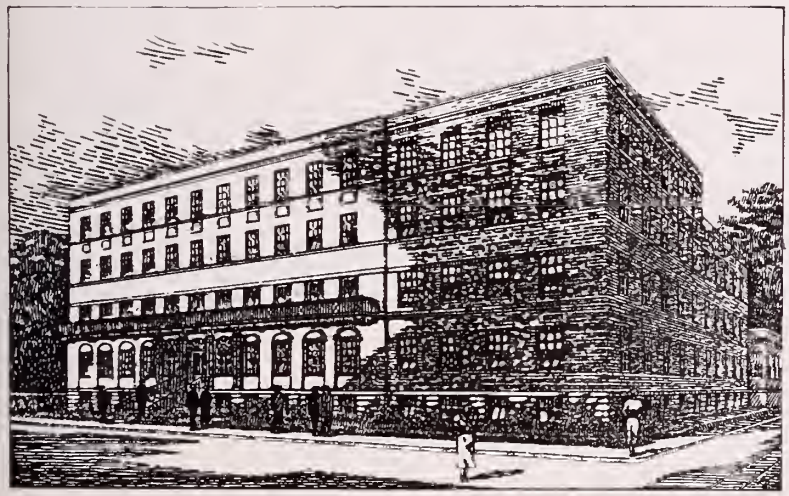

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George F. Bond, M. D.
Bat Cave, North Carolina

May 23, 1950

Mr. Charles Lively
Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia

Dear Mr. Lively:

I am in receipt of your letter of May 19, and should like to take this opportunity to thank you and all participants in the recent rural health conference for your splendid hospitality and for the remarkably pleasant reception that you gave to my wife and me during our recent visit.

Aside from having greatly enjoyed the opportunity to see so much of the state and to have a first hand acquaintance with some of your problems in rural practice, I am most enthusiastic over the obvious desire of all members participating in the conference to get something done. In the several years that I have had occasion to work with groups on rural health problems, I may say that I have never seen such enthusiasm or such practical down to earth proposals along these lines. Most especially I am encouraged that your State Medical Association is itself interested in this problem and making the foremost effort to seek a solution; I wish that this were so in other State Medical Societies throughout the states.

Looking forward to seeing much progress along these lines in your state in the coming 12 months and in the anticipation of being with you at another rural conference, I am

Very sincerely yours,

GFB:eb George F. Bond, M. D.

AMERICAN MEDICINE ACCEPTS CHALLENGE

The medical profession, by practice and tradition, has been so occupied serving the welfare of the public, individually and collectively, that it has had little time or inclination to learn the great art of propaganda and public relations. It now faces the threat of encroachment by political government and by cultists.

No other profession has been signaled out and been brought under such violent attack by those ambitious for political power over it. These ambitious politicians threw down the gauntlet—a threat to the Nation's health, as well as the basic freedom of our profession—and the challenge was accepted by American Medicine. We expected and received outside criticism—in plenty. To this threat our defense was the widest possible dissemination of the truth, by every possible means.

The reason that the American Medical Association is not hesitant in accepting this challenge, is the oblique approach of supporters of extreme legislation. In this oblique approach lie the dangers of confusion, misinformation and misrepresentation. Only truth can conquer this unholy triumvirate.—New York Medicine.

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So many a physician has said to himself that he could help many of his parentally mismanaged patients if only he could get them away from home. Justified fear of losing his patients deters him from making any such recommendations. Illness, necessitating admission to a hospital, comes as an answer to his prayers.

The spoiled, over-protected child is away from his agitated mother, and there is a chance to re-educate the child who has temper trantrums, indulgence in food capriciousness with or without vomiting, who is the object of parental bowel overconcern that works with laxatives, suppositories and enemas, has innumerable aches and pains, is afraid of the dark, and gets everything he wants.

Successful management of these problems in the hospital can be made to serve as a forceful demonstration to the parents of adequate methods of training. But there must be people on the staff who have learned how to deal with such children and their parents, and of course the public health nurse can see that the hospital management of the problem is continued in the home—or a return to the original difficulty will be the result.—David A. Sher, M. D., in Minnesota Medicine.

PERSONAL CONTRIBUTION TO CANCER CONTROL

The most significant personal contribution a layman can make to cancer control is to have a periodic medical examination by his own physician. Cancer in its early stages—where the percentage of cure has shown marked increase—can never be discovered in any other way. Better a dozen negative examinations than neglect one when cancer could have been found in an early stage.—Donald E. Johnson, M. D., in J. Mich. St. Med. Soc.

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THE "ISM" MANIA

Nowadays when sociological planning is couched largely in "ism" words, it is interesting to consider a literal application of the theories being propounded. The Colorado Department of Agriculture makes its translation of theory by means of a simple bovine equation, thus:

Idealism: If you have two cows you milk them both, use all the milk you need and have enough left for everyone else.

Socialism: If you have two cows, you keep one and give the other to your neighbor.

Communism: If you have two cows, you give both to the Government; then the Government gives you back some milk.

Soft-Pink Communism: If you have two cows, you're a capitalist.

Imperialism: If you have two cows, you steal somebody's bull.

Capitalism: If you have two cows, you sell one cow and buy a bull.

New Dealism: If you have two cows, the government shoots one cow, you milk the other cow, then throw part of the milk down the sink.

Anarchism: If you have two cows, your neighbor shoots one and takes the other.

Nazism: If you have two cows, the government shoots you and takes both cows.

Realism: If you have two cows, they're both dry.—Minnesota Medicine.

IT'S THE WAY THEY SAY IT

Hospital telephone girls have a lot to put up with, of course, what with irate surgeons and bare inquiries like "How's our Ada tonight?" But they could profitably study standing orders for telephonists at, say, a West End Shop.

It's as nice to hear a pleasant voice say immediately, "Selfishes, good morning," as it is to get an unexpected smile from a pretty girl on the bus. Why, even if you ring PAD 7000 a delightful young soprano exclaims "Paddington Station, may I help you?" Try it and see.

But my favourite call is to a ladies' hairdressers round the corner which I discovered one day with a lucky wrong number. I'll spend tuppence any time just to hear that delicious voice say eagerly, sweetly, but with the inflection that infers she means business: "Madame Pompadour, at your service."—The Lancet.

One of the new hormones has been found to be plentiful in Mexico—extracted from a Mexican yam. Now if they can cross a Mexican yam with a Mexican jumping bean maybe they can synthesize a concoction that would cure that great American disease called the "jitters."—J. J. L. in Detroit Medical News.

Permission for air travel should be carefully weighed where there is anemia, angina, heart disease, hypertension, acute upper respiratory infection, chronic bronchitis, active tuberculosis, pneumothorax, active peptic ulcer or acute infectious disease.—W. S. R. in Detroit Medical News.

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Vol. XLVI AUGUST, 1950 No. 8

THE PATHOLOGIC PHYSIOLOGY OF BENIGN PROSTATIC HYPERTROPHY*

By A. KYLE BUSH, M. D.
Philippi, W. Va.

INTRODUCTION

It is the purpose of this paper to present, by use of illustrative cases, the concepts of pathologic physiology which occur in benign prostatic hypertrophy with vesical neck obstruction.

ETIOLOGY

For several centuries, prostatic hypertrophy has been recognized, but its causation has not been fully explained. There are at least three theories which have been advanced to explain this condition.

According to Demings,[2,3,4] the primary enlargement begins as a fibromuscular mass in the musculature of the prostatic urethra. This mass stimulates the epithelial elements of the ducts with resulting hyperplasia which then invades the stroma of the fibromuscular nodule and often practically replaces it with glandular elements.

During the climateric period, prostatic hypertrophy is prone to appear. This has led to the "hormonal theory" which postulates increasing amounts of estrogens and diminution in the production of androgens. The increasing estrogen produces metaplasia of the ductal epithelium and then hypertrophy. The injection of estrogens in mice leads to ductal metaplasia[1,7] which is analagous to that seen in human subjects. Therefore, the change in the ratio of estrogens to androgens with a predominance of estrogenic hormones may be a factor in the production of benign prostatic hypertrophy.

The third theory postulates the production of a hormone "inhibin" by the spermatogenic elements of the testes. This hormone inhibits the production of gonadotropins by the anterior pituitary. During the climateric period, the spermatogenic elements fail and "inhibin" decreases with a resulting rise in the gonadotropins which stimulate the interstitial cells to produce increasing amounts of androgens (testosterone). Testosterone acts directly upon the prostate, and hyperplasia results.[5,6]

PATHOLOGIC PHYSIOLOGY

The pathologic physiology of vesical neck obstruction can be discussed under (1) the hydrostatic effects on the bladder, ureter, renal pelvis and kidney and (2) the effects on renal function.

As the prostate enlarges there is gradual obstruction of the vesical neck which leads to increased resistance. The detrusor muscles respond with hypertrophy in order to maintain compensation and to empty the bladder. Extreme hypertrophy of the bladder wall may result and the symptoms of frequency and nocturia, occur because of lessened bladder capacity. An intravesical pressure as great as 80 mm. of water may result. There arrives a time when the compensation is broken and the bladder enlarges. This causes an increasing amount of residual urine and the formation of diverticula. Complete obstruction may then supervene.

The ureters enter the bladder wall at an oblique angle and, as the bladder wall hypertrophies, increased resistance to their emptying

*Photos Courtesy Richard Crawford, Photography Department, Myers Clinic Hospital, Philippi, W. Va.

occurs. Peristalsis increases in order to force the urine into the bladder. Some hypertrophy of the muscular wall may occur, but because of the thinness of the musculature, dilatation occurs and hydroureters result. As the bladder decompensates, the ureterovesical junction becomes incompetent and the hydrostatic pressure from the bladder is transmitted into the ureters and the pelvis of the kidney.

The renal pelvis is next involved since increased pressure in the ureter is transmitted to this region. If the pelvis is extrarenal, dilatation will occur earlier than if it is intrarenal. The kidney substance prevents dilatation in the latter case.

The hydronephrosis that results leads to hydronephrotic atrophy of the kidney substance from pressure and dilatation of the renal tubules. The blood supply may be somewhat impaired, with the resulting likelihood of anemic atrophy of the kidney.

The end result is diminished kidney function which is further impaired by infection which inevitably occurs. The changes are chiefly of a tubular type and are reversible if proper treatment is not delayed too long.

Case 1.—Mr. E. J. B., age 69, was admitted to the hospital Oct. 30, 1949, in a semi-conscious state of two days' duration. According to the history there had been an onset of dyspnea on October 21 for which he had consulted his family physician and was given some "heart medicine." This brought about improvement for a period of one week at the end of which time frequency, dysuria and nocturia developed. Urinalysis revealed "pus in the urine" and he was placed on a "sulfa-drug." Two days later, he again collapsed and was admitted to the hospital as previously stated.

Family history and past history were negative except for right herniorrhaphy performed in 1947.

The physical examination revealed a chronically ill, semicomatosed white male who appeared to be much older than his stated age of 69 years.

The skin was dry and loose with extensive scarring in the right axilla from a previous burn. The pupils were small, regular and reacted sluggishly to light. There were crepitant rales at the left base posteriorly. The heart was enlarged to the left, with irregularly irregular rhythm and a systolic blow at the apex.

There were no masses in the abdomen. An indwelling catheter was present.

The prostate showed a grade III enlargement with an obliterated median sulcus, and was firm on palpation.

The rest of the examination was negative.

Clinical impressions were:

1. Benign prostatic hypertrophy.
2. Uremia.
3. Generalized arteriosclerosis.
4. Arteriosclerotic heart disease with auricular fibrillation.

The urinalysis showed the urine to be red in color, acid in reaction, negative for sugar, albumin (3 plus), 200-300 red blood cells per high power field and an occasional white blood cell. The B. U. N. was 35 mg./100 cc. The blood chlorides were 690 mg./100 cc. The CO_2 combining power was 17 volumes per cent CO_2/100 cc. plasma.

The blood count showed 3,000,000 red blood cells, 8 Gm. (52%) hemoglobin, color index 0.87. There were 18,000 white blood cells with 93% neutrophiles (59% filamented, 34% nonfilamented), 6% lymphocytes and 1% monocytes.

The patient was treated by intravenous fluids of sodium lactate, glucose in distilled water and whole blood to correct dehydration and acidosis. Constant gastric lavage with sodium bicarbonate was instituted to counteract the uremia. The amount of fluids given was controlled by blood chemistry examinations and physical examination of the patient. The acidosis was rapidly controlled. The patient's condition remained about the same in that he failed to regain consciousness. A lumbar puncture showed increased protein to 15 mg./100 cc., 19 white blood cells and 64 red blood cells. This was felt to represent some cerebral damage, probably the result of hemorrhage.

The patient expired on the eighth hospital day.

A complete postmortem examination which was performed by Dr. S. D. Wu revealed the following:

1. Hypertrophy of prostate with marked median bar causing obstruction of urethra.
2. Hypertrophy and dilatation of urinary bladder.
3. Diverticulum of wall of urinary bladder.
4. Bilateral hydroureter with hydronephrosis. (This was considered to be the cause of his renal failure or uremia.)
5. Hypertrophy and dilatation of heart.
6. Chronic subacute cardiac and mitral valvulitis.
7. Lobular and purulent bronchiolitis.
8. Diverticula of distal duodenum.

9. Recent infarct of the brain (parietal cortex).

10. Arteriosclerosis, general, i. e., cerebral vessels.

11. Cloudy swelling of the liver.

The observation regarding the urinary tract were as follows:

"The right kidney is appreciably large and shows a very much cystically dilated pelvis. Similar changes are also found in the left kidney to a lesser extent and degree. For this reason, the organs are not weighed but are preserved with the ureters and bladder in continuity. Both ureters are moderately dilated.

"Cut sections of both kidneys show extensive saccular dilation of the calyces and thinning of the renal substance. The urinary bladder is somewhat dilated and shows a diverticulum in the apex. This diverticulum measures 3 cm. horizontally and 2 cm. away from the lining of the wall of the bladder.

"The mucous membrane of the urinary bladder shows patches of hemorrhage.

"The prostate is greatly enlarged and shows a very prominent nodule posteriorly which has blocked the orifice of the urethra at the level of the internal sphincter." (Fig. 1).

Case 2.—Mr. E. B. S., a 67 year old white male, was admitted on Feb. 16, 1943, with a history of occasional urinary difficulties for the past nine years. The onset accompanied an acute urinary infection with burning on urination, chills and fever. He was treated by his local doctor, with partial recovery. For three years there was nocturia two to six times per night. The prostate was said to be enlarged two to three times normal size and was treated by repeated massage. The symptoms of frequency, occasional dysuria, nocturia, difficulty in starting the stream and incontinence progressed. In 1940, he was advised to have kidney function tests, pyelograms and a transurethral resection which was refused.

Fig. 1. End result of prostatic hypertrophy: Dilatation and hypertrophy of bladder wall, bilateral hydroureters and bilateral hydronephrosis.

In Feb. 1943, the patient began to experience sharp pains in the region of the kidneys which were worse after voiding, nocturia six to eight times per night with increasing incontinence, and difficulty starting the stream.

The family history and past history were irrelevant. The patient gave a history of irritation around the rectum and mild dyspnea on exertion.

Physical examination at this time revealed the blood pressure to be 176/102. The heart was enlarged with the P. M. I. just outside the midclavicular line. The rate and rhythm were regular and the heart tones were of good quality.

The abdomen apparently was negative except for bilateral tenderness in the costovertebral angle. The prostate showed grade II enlargement and was somewhat nodular, but elastic. The median sulcus was obliterated. The patient was instructed to void and was then catheterized, 120 cc. of residual urine being obtained.

X-ray intravenous urograms were taken with the following report:

"Examination of the abdomen with special reference to the urinary tract and before and after the use of intravenous diodrast presents a marked osteoarthrosis of the lumbar spine with lipping and spur formation tending to partially bridge the lumbar vertebrae and especially the sacrolumbar articulation. Condensation changes are seen also in the left sacroiliac synchrondrosis. The renal outlines are enlarged. The other denser abdominal organs do not appear abnormal so far as can be told on this film, although considerable detail is lost due to gas and extraneous material in the colon. Practically no visualization is obtained in the 10 and 25 minute films. At 75 minutes, there is fair visualization of the right renal pelvis and ureter, the latter appearing to be tortuous and 'kinked' in three places. The left ureteropelvis is represented by a 'blurring'. Examination at 135 minutes and 195 minutes shows continued filling so that the left pelvis is now seen to be considerably enlarged. The left ureter

is possibly four times normal size and is not visualized throughout. Separate calyces are not discerned in the left pelvis but there are rounded separate masses. In the right pelvis, the terminal calyces are blunted and there is considerable hydronephrosis. It is to be repeated after the use of retrograde filling. There is, however, an encroachment of a moderately enlarged prostate. Several small rounded densities within the limits of the bony pelvis and having radiolucent centers represent phleboliths.

"CONCLUSION: Bilateral hydronephrosis; pyonephrosis on left." (Fig. 2).

"Reexamination of the bladder with the use of contrast media presents a small irregular bladder with a large diverticulum which is best seen in the left oblique projection and which measures 3 x 5 cm.

"IMPRESSION: Diverticulum of bladder." (Fig. 3).

The red blood cells were 4,100,000; hemoglobin, 13 Gm. (78%); white blood cells 14,000, 72% were polymorphonuclear (of which 44% were filamented and 28% nonfilamented), 22% were lymphocytes and 6% monocytes. The B. U. N. was 25.8 mg./100 cc. This was repeated on Feb. 27, 1943, and found to be 20 mg./100 cc. The P. S. P. test of kidney function was found to be 49% clearance in two hours on repeated tests. The urine culture revealed E. coli.

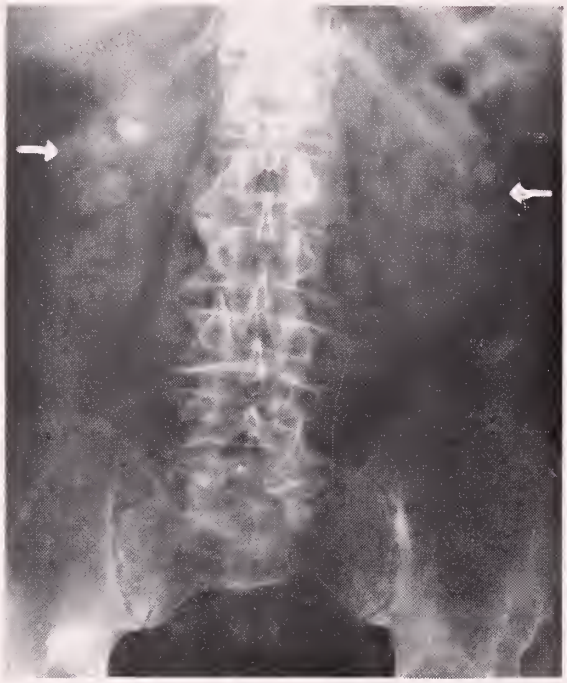

Fig. 2. Bilateral hydronephrosis due to benign prostatic hypertrophy. Excretory urograms showing greatly reduced kidney function.

Fig. 3. Diverticulum of bladder resulting from vesicle neck obstruction.

Prior to surgery an indwelling catheter was left in place for one week and the patient given sulfadiazine Gm. 1, five times daily. A routine transurethral prostatic resection with vasectomy was performed March 1, 1943. About 30 Gm. of tissue was resected. The intermittent irrigator was used for twenty-four hours to prevent clots from forming in the bladder. Convalescence was rapid and uneventful, the patient being discharged on the sixth postoperative day.

The patient returned on the twelfth postoperative day with slight bleeding. The bladder was irrigated with the Ellik evacuator. The bleeding area was resected and the vessels coagulated. The patient was discharged four days later in good condition.

This case was followed routinely. There remained some nocturia but the prostate showed only grade I enlargement and there was less than 20 cc. of residual urine.

On December 31, 1945, repeat pyelograms were reported as follows:

"Reexamination of the abdomen, with especial reference to the urinary tract, and before and after the use of intravenous diodrast, presents no essential change in any portion of the bony structure or denser abdominal organs on the films which were taken without previous preparation. On the film taken 35 minutes following intravenous diodrast, there is adequate visualization of both urinary tracts, and these appear to be within

normal limits of size and configuration. The diverticulum of the bladder previously mentioned appears smaller. It is considered that this represents a remarkable recovery both of renal form and function following transurethral prostatic resection." (Fig. 4).

The interstitial cystitis has remained in spite of various chemotherapeutic and antibiotic agents.

DISCUSSION

In Case 1 the end results of prostatism with vesical neck obstruction are well illustrated: the hypertrophied bladder, the hydroureters and bilateral hydronephrosis with anemic and hydronephrotic atrophy of kidney substance with resulting uremia.

When a patient with symptoms of prostatism such as frequency, urgency and nocturia presents himself, a thorough physical examination should be made. A rectal examination will reveal the degree of enlargement, and the consistency of the prostate plus nodularity will help determine the type of hypertrophy which is present, that is, whether it is a fibrous, glandular, mixed type, or a malignancy. A routine urinalysis is a rough index of the presence of infection or bleeding. A good criterion as to whether or not an operation is indicated is to have the patient void and then to catheterize him for residual urine. If the amount of residual urine is greater than 30 cc., we consider that an operation is indicated.

The second case illustrates that even in the case of advanced disease, with changes reflected in the bladder, ureters and kidneys, reversal to a normal state can be accomplished by proper treatment.

There is no one operation applicable to all types of prostatic hypertrophy. Various methods can be used such as transurethral resection, retropubic prostatectomy, suprapubic prostatectomy or perineal prostatectomy. The operation should be fitted to the patient and not the patient to the operation. Good results may be expected from any of the aforementioned procedures if the operation is carefully selected and properly executed.

Before operation a complete blood count, a urinalysis, a blood urea nitrogen test and a kidney function test such as P. S. P. test should be performed. An attempt should be made to bring all within normal limits before proceeding with the operation.

SUMMARY

1. The etiologic theories of prostatic hypertrophy have been discussed.

2. The pathologic physiology of prostatic hypertrophy with increasing hydrostatic pressure leading to anemic and hydronephrotic atrophy of the kidneys with decreasing urinary function have been traced.

3. Symptoms of prostatism should be recognized and, when residual urine is 30 cc. or more, definitive surgery should be performed.

4. An illustrative case showing the end result of untreated vesical neck obstruction has been presented, likewise a second case which demonstrates that the process is reversible provided treatment is not delayed too long.

Fig. 4. Same patient as figure 2. Excretory urograms taken two years following transurethral resection with return of kidney pelvices to normal.

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In the temperate-zone countries, diphtheria, whooping cough and measles still constitute the chief cause of death among pre-school children.—R. N.

BARBITURATE POISONING
(Case Report)

By ARTHUR RAY FLEMING, M. D.
Weston, W. Va.

A 34 year old male was admitted to the Medical Center of Weston State Hospital, February 12, 1950, at 4:00 o'clock, in a comatose condition. The history, although not completely reliable, showed that the patient had ingested approximately 80 gr. of sodium amytal at 11:30 o'clock the previous evening. He was first discovered at 8:30 a. m. the day following his act, and was treated quite adequately in the home until the hour of his admission to the hospital.

A cursory examination on admission showed his temperature to be 104.5 F. (axillary), pulse 120-140 designated as pulsus alternans with no response to carotid sinus pressure unilaterally or bilaterally, nor to orbital pressure. The rate was 40-50 per minute and best described as shallow, gasping and stertorous. The blood pressure was not obtainable.

Cardiorespiratory signs indicated general peripherovascular collapse associated with shock and extreme cyanosis. Heart sounds were not heard because of noisy respirations resulting from fluid accumulation in the upper respiratory tract. Neurologically, the patient showed pinpoint pupils which within a few hours after admission became dilated and fixed. All reflexes were absent including the corneal reflex. The general muscle tone was completely flaccid and no response was elicited to ordinarily extremely painful stimuli.

The treatment following admission consisted of one picrotoxin ampue intravenously every fifteen minutes. However, after the first night, this stimulant was used only as dictated by the patient's condition. Continuous oxygen was, of course, given via mask since an oxygen tent was not available. One thousand cc. of 5% glucose in Ringer's solution was given intravenously and strychnine gr. 1/60 was administered intramuscularly. An airway was inserted and approximately 100 to 150 cc. of greenish purulent mucous was aspirated from the upper respiratory tract using a regular suction apparatus and a catheter. Penicillin was instituted with the dosage schedule set at 100,000 units every three hours intramuscularly.

The first intravenous was permitted to run too rapidly and I feel that it increased the pulmonary edema; intravenous fluids thereafter were set to drip very slowly in order to obviate this effect. The fever and pneumonic signs were considered justifiable basis for the penicillin. Furthermore, in the terminal phases of barbiturate poisoning, pneumonia is a common complicating process.

During the four hour interval just described a parenteral preparation of amphetamine sulfate was obtained from a neighboring town. The patient's condition had shown little, if any, change until this drug was administered. At 9:30 p. m. he was given 20 mg. of amphetamine sulfate intravenously. His respirations improved immediately; however, this improvement lasted only one to two minutes. At 10:00 p. m. this dosage was repeated but given more slowly and mixed with 10 cc. of sterile distilled water. The effect was not as notable with this second dose.

The patient was then given 10 mg. of strychnine intramuscularly and an intravenous infusion of 1000 cc. of 5% glucose in Ringer's solution with 40 mg. of amphetamine sulfate, and 20 cc. of picrotoxin was started. The rate of drip was slow in order to give continuous stimulation throughout the remainder of the night and to guarantee a vein for emergency use. This did not prove adequate and the patient was given an ampule each of coramine and caffiene sodium benzoate at 12:05 a. m. and 4:20 a. m. Other medications administered during the night included atropine sulfate gr. 1/150 at 12:35 a. m. and repeated at 5:00 a. m. At 2:20 a. m. the patient was given 1 cc. of adrenalin 1-1000 intravenously. At this same time the fever was noted to be 105.6 F. (axillary) and an ice water enema was given to lower the fever. The enema worked well and the fever did not return to alarming heights until 8:00 a. m., or 5 hours and 40 minutes later.

At 4:20 a. m., immediately following the intravenous administration of one ampule each of coramine and caffiene sodium benzoate, the patient first moved — a slight motion of one hand. This evidently was the turning point for from this time on his condition continued to improve although it remained very critical for the next few days. During this time the patient was digitalized and received several intravenous injections of thiamine hydrochloride and ascorbic acid. Periodically, the patient required picrotoxin and other stimulants. The fever remained high and there was much discussion concerning the possibility of the fever being of central nervous system origin. The fever and hypoxia placed the central nervous system in great jeopardy and even if the patient recovered we were afraid of residual damage. Since prolonged high fever in itself is quite capable of causing permanent central nervous system damage, we felt justified in packing the patient in fifty pounds of chipped ice for one hour. It was agreed that this procedure be repeated at any time that the fever rose above 105 F. The ice pack lowered the fever promptly to 98.2 F. but the effect lasted only two hours

longer than did that of the ice water enema previously used for the same purpose.

The patient was talking freely but with periods of irrationality by the early afternoon of the fourth hospital day. All medications except general supportive measures were discontinued by the fifth and sixth hospital days. The patient had received a total of 3,000,000 units of penicillin, 57 cc. of picrotoxin, 6 cc. of caffeine sodium benzoate, 7 cc. of coramine, and 110 mg. of aphetamine sulfate.

During the fourth and part of the fifth hospital day the patient remained fairly rational only to display marked hallucinations and delusions on the afternoon of the fifth hospital day. These psychotic signs were of a bizarre, paranoid nature. For the most part he was suspicious, excited and fearful. This condition necessitated restraint, and persisted until the twelfth hospital day. With hydrotherapy in the form of prolonged tub baths the toxic psychosis subsided and the patient was discharged on the nineteenth hospital day, symptom free.

Criticism.—This patient should have received a gastric lavage following which 30-60 Gm. of magnesium sulfate should have been instilled through the lavage tube. This procedure could have been carried out either at home or when the patient was first admitted to the hospital. Digitalization probably should have been accomplished sooner. Plasma and/or whole blood should have been used to combat the peripherovascular shock. The pneumonic condition demanded more judicial use of the fluids which the patient received. It is also felt that the stimulants were used a bit hurriedly, particularly after the third hospital day and in the early morning hours. We must beware of interpreting rest as relapse, remembering that the body metabolism is normally lower during the early morning hours. In general, treatment should have been better systematized and controlled. The recovery in this case can be attributed to no one particular factor or drug.

SUMMARY

A case of barbiturate poisoning in which the patient admitted taking approximately 80 gr. of sodium amytal is presented. The patient was first discovered about nine hours after taking this drug. He was treated at home for eight hours prior to admission. Treatment with the commonly used stimulants and general supportive measures was believed to be helpful. Hydrotherapy in the form of prolonged tub baths and steam baths quieted the toxic psychosis which followed the acute intoxication. The patient is now well and is working.

CONSERVATIVE RENAL SURGERY

By EDGAR W. KIRBY, JR., M. D.
Bluefield, W. Va.

This paper is presented with the purpose of making a plea for a more conservative attitude toward the kidneys. It is true that we are blessed by having two such organs and, under normal conditions, an individual can lead a normal healthy life after one kidney has been removed. No doubt many nephrectomies are done because it is an easy way out and does not tax the skill of the operator to perform a plastic operation on the kidney. I do not mean to say that nephectomy is never in order; at times it certainly is. There will always be instances where nephrectomy is the procedure of choice and anything less will be unsatisfactory and detrimental to the clinical well being of the patient. Nevertheless, all things being equal, it should be our aim whenever possible to conserve as much renal tissue as we can.

By conservative renal surgery is meant any renal surgery short of nephrectomy whereby good cortical tissue is preserved, or the flow of urine from the renal pelvis has been corrected so that the kidney function may be maintained or improved. Before any thought of conservative surgery can be entertained, it is imperative that the patient be examined completely from a general point of view plus complete urologic studies, including bacteriologic studies of the bladder urine and of both kidney urines. Differential renal function tests, including intravenous urograms, if necessary, and bilateral pyelo-ureterograms in the supine and upright position are desirable, also. One must have a fairly good idea as to what he can expect from the kidney in question as to its function and how much and what type of infection is present before he can make the decision as to whether or not conservative renal surgery is indicated. Even so, in the last analysis, the ultimate decision will rest with the operating surgeon at the time of operation. It is important also to take into consideration the age of the patient, since a young person, having a longer life expectancy, may at some future period be called upon for utilization of all available renal tissue. Thus in the young patient especially will it behoove us to conserve as much renal tissue as possible. The sex of the individual likewise must be taken into account, particularly a female in the child-bearing period of life. During the child-bearing period we know that renal conditions may develop which may tax every available bit of renal tissue present. On the other hand, in the elderly patient, when the opposite kidney has good function, one perhaps may be justified in not attempting to conserve the kidneys, as the re-

maining one may quite readily suffice for the remainder of his life.

One of the most common reasons for nephrectomy is hydronephrosis. This condition is secondary to some obstructive element at the pelvo-ureteral junction and, in many instances, is congenital. Occasionally one finds intrinsic narrowing at the pelvo-ureteral junction which we may call a stricture. This of course can be handled conservatively, i. e., by ureteral dilitations and repeated follow-up examinations; if there is no change for the worse in renal function, nor any change in the size of the hydronephrosis, the patient can be watched. If the hydronephrosis should progress, the patient should be a candidate for conservative renal surgery. One must remember the fact that hydronephrosis is potentially a bilateral affair, and Sargent points out that with careful study of the opposite kidney, a similar condition frequently will be found in the process of formation. The potential obstructive element to the normal kidney may not be appreciated, but when the added burden is thrown upon it after removal of its fellow, the increased urinary output results in inadequate drainage, and hydronephrosis gradually develops. Fite expresses the opinion that when the opposite kidney shows any pathology a hydronephrotic kidney with any function should not be removed unless it threatens the patient's life.

Aberrant blood vessels and fibrous bands are not uncommon obstructive lesions found at the pelvo-ureteral junction. Figure 1 represents the

Fig. 1

Fig. 2

case of a twelve year old boy with hydronephrosis on the right, secondary to an aberrant blood vessel at the pelvo-ureteral junction. He was subject to repeated attacks of fever, renal pain and pyuria. Previously a diagnosis of left hydronephrosis was made, and a plastic operation performed on that side by another urologist. The first x-ray shows the typical hydronephrosis with obstruction at the pelvo-ureteral junction. The function of this kidney was diminished. The knowledge that the opposite kidney had been damaged made it imperative that the right kidney be conserved. The second film one year postoperatively shows a remarkable return of the kidney to normal, the drainage being good. This boy is now living normally and his life expectancy has been increased.

Figure 2 is the case of a 57 year old woman who was having considerable pain in the right flank. Investigation showed hydronephrosis of the right kidney which was proved at operation to be due to a constricting band at the pelvo-ureteral junction. The function was good. The postoperative result was good, there being good drainage from the renal pelvis which ultimately returned to a more normal outline. The patient is now free of pain and enjoying good health.

Figure 3 is that of a 19 year old married woman who was admitted to the hospital very ill with right pyelonephritis. It was necessary to institute ureteral catheter drainage of the right kidney before she became afebrile. The function of this kidney returned with drainage and the pyelogram

showed an obstruction at the pelvo-ureteral junction. With removal of the ureteral catheter she became ill again. After adequate drainage the kidney was explored. The obstruction was found to be due to a fibrous band. She did well following conservative surgery. The postoperative pyelogram shows a normal outlet at the pelvo-ureteral junction. She has done well, and very recently went through a normal pregnancy without difficulty.

It is very important to remember that the kidney has a remarkable power of regeneration and that even though the function may be low at the time of examination, the kidney may be able to come back to almost normal function. Sargent believes that nephrectomy is indicated in those cases in which the kidney is known to be non-functioning, likewise in those cases in which plastic corrective procedures have failed. The mere fact that function of a kidney is considerably diminished in itself is no indication for nephrectomy. Even if there is considerable infection and the function not too dangerously impaired, we may possibly expect good results due to the fact that we now have newer and better urinary antiseptics.

It would not be fair to create the impression that everything always goes along fine and that results of all plastic operations at the pelvo-ureteral junction are good. Such is not the case. There are bad results which naturally worry us, and ultimately nephrectomy has to be performed.

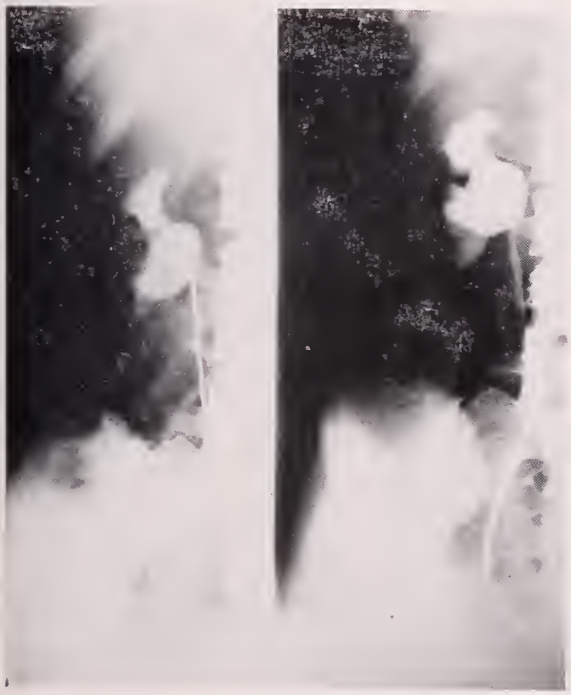

Fig. 3

Fig. 4

In figure 4 we see left hydronephrosis in a 19 year old boy. At operation this was found to be caused by an aberrant blood vessel at the pelvo-ureteral junction. The obstruction was removed and a plastic procedure at the pelvo-ureteral junction performed. The patient did very nicely while in the hospital and, as one can see in the next film, there was good funneling at the pelvo-ureteral junction; yet a defect remained which we were unable to explain. After leaving the hospital the patient continued to have pain in that kidney, with infection. The next film shows that stones had developed in that kidney which was then re-explored. There was noted at the pelvo-ureteral junction, and completely encircling it, a cuff of fibrous tissue about an inch in diameter. Nephrectomy was necessary for cure. Even though one has a failure every now and then and nephrectomy has to be performed, it is still wise to be as conservative as possible because in the long run more kidneys will be saved than will have to be sacrificed.

There are a number of conditions in which conservative renal surgery may be indicated. In some instances of cyst of the kidney, particularly of those located at the upper or lower pole, that portion of the kidney may be removed and the remainder preserved, provided the blood supply is not disturbed. In case of obstruction to an infundibulum with hydrocalyx when it is located in either the upper or lower pole of the kidney, the involved portion may be removed and the remainder saved. In cases in which a calculus is

obstructing an infundibulum, or a calculus is located in a dilated calyx, involving either the upper or lower pole of the kidney, the involved portion may be removed too. Also, in cases of bifid renal pelvis with infection or stones in the upper or lower portion, conservative surgery may be instituted.

Figure 5 is the case of a 22 year old married woman with bifid renal pelvis and ureter to the middle third of the right ureter, with hydronephrosis and hydro-ureter involving the upper pelvis, which contained a stone. The lower pelvis was normal, with good function. Partial nephrectomy, removing the upper one-third of the kidney, was performed. The postoperative intravenous pyelogram shows a normal functioning remaining two-thirds of the kidney. As can be seen, the result here is worth the effort expended and the patient apparently has sufficient kidney tissue to go through life.

In certain other congenital conditions such as ectopic ureters draining into the urethra and vagina, likewise reduplication of the ureters, conservative renal surgery can be resorted to, depending on the function and pathologic changes in the kidney.

Figure 6 is the case of a 16 year old girl who was constantly wet with urine, as a result of which she was almost completely ostracized from society. Examination showed that the urine was coming from an ectopic ureteral opening into the urethra. The pyelogram shows a normal lower renal pelvis with its ureter entering into the bladder at the normal position. The ectopic ureter entering the urethra was markedly dilated, with corresponding hydronephrosis which represented the upper renal pelvis. This upper part of the kidney was removed, the lower two-thirds being conserved. The postoperative pyelogram shows a normal pelvis representing the conserved lower two-thirds of the kidney. This girl is in the child-bearing period and it may well be that the preserved tissue may eventually stand her in good stead.

Fig. 5

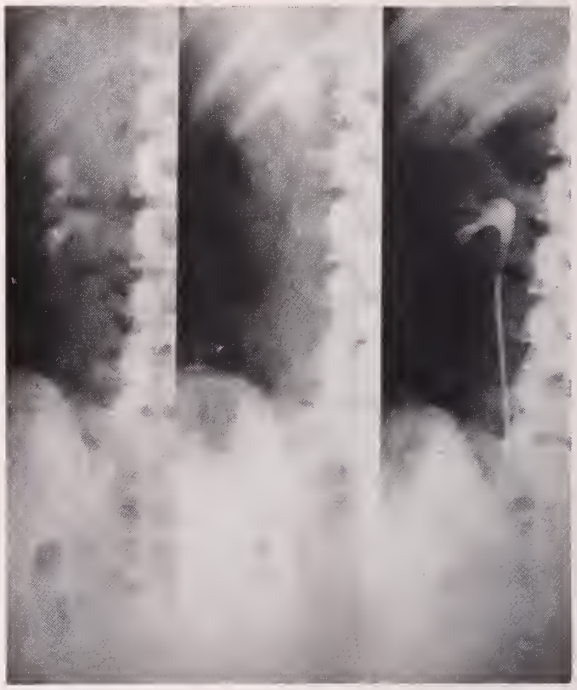

Fig. 6

Another reason for nephrectomy is the presence of stones. There may be a tendency, when the diagnosis of kidney stone is made, to perform nephrectomy, more especially after the kidney is exposed and the stone cannot be located. Even in instances in which there are staghorn stones, it does not necessarily mean that the kidney has to be sacrificed. Now, with better knowledge of the physiology of the kidney and a better understanding of the possible causes or factors of stone formation, and with the newer urinary antiseptics, we may be able to save many kidneys that would ordinarily have been removed.

Figure 7 shows the x-rays of a young woman who had a staghorn stone in the right renal pelvis. This kidney had an E. coli infection but its function was good. As one can see, the stone filled the entire renal pelvis. She was operated upon, and on finding the renal parenchyma to be good, the stone was removed. The urinary infection subsided under treatment and finally disappeared

entirely. A film one year later shows that there has been no recurrence of the stone.

Every now and then during an operation in or around the kidney, accidents will occur whereupon the ureter is divided. The mere division of a ureter does not justify nephrectomy and the defect should be repaired. In figure 8 is seen a pyelogram which shows a stone in a large upper infundibulum which cannot be visualized too well. This lady previously had been operated upon elsewhere, nephropexy having been performed because of pain thought to be due to ptosis. The pain was never relieved. The function of the kidney was good. At operation it was found that the kidney was densely bound down with scar tissue, and the ureter displaced laterally. In the process of dissecting free the posterior surface of the pelvic body, the ureter was accidentally severed. The operation was completed, that is, the stone was removed and the ureter repaired. As can be seen, the postoperative result was good and she has a normally draining right urinary tract.

In the lower end of the ureter all types of plastic procedures including re-implantations and anastomoses may be performed in an effort to conserve renal tissue. In most instances these procedures will be satisfactory and preclude the necessity for nephrectomy. In some instances of tumors located in the ureter when one is relatively certain that the condition is benign, plastic procedures may be performed and the tumor excised locally with the resultant saving of a kidney. However, in such instances the patient must be followed very closely and carefully over an extended period of time to pick up any recurrence if such should develop.

Fig. 7

Fig. 8

Another reason for nephrectomy is renal trauma. Even though the injury to the kidney may be rather extensive, with a perirenal hematoma, it does not necessarily mean that the kidney should be sacrificed. Unless the life of the patient is at stake at that moment, it would be wise to observe him over a period of 48 to 72 hours. If this can be done, a surprising number of kidneys can be saved. In such surgical emergencies the necessity of an intravenous urogram cannot be overemphasized because certainly one wants to be sure that an opposite kidney is present before he entertains any thought of nephrectomy.

It is not intended in this discussion to go into detail about various operative procedures pertaining to the pelvo-ureteral junction or to other parts of the kidney. Each case is an entity, and the procedure of choice has to be decided at the operating table. In general, the important points are removal of obstruction, creating adequate drainage from the renal pelvis by means of any of a number of procedures, and splinting the ureter over an adequate period of time with or without nephrexy as seems to be indicated.

In conclusion, it is important to remember that the kidneys have remarkable regenerative power and that what looks like a bad kidney at the moment may turn out to be one with reasonably

good function which can be conserved in whole or in part if good judgment prevails.

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DIET AND AGING

There are several factors which tend to create malnutrition of the aged. They are related to social and economic conditions (low incomes, poor cooking facilities), mental outlook (worry from insecurity, ignorance of nutritional facts, mental deterioration), physical factors (lack of exercise, poor teeth), and pathologic conditions (inadequate amount of hydrocloric acid.

The complex etiology is illustrated in the case of anemia of nutritional origin. It may result from inadequate income for the purchase of eggs and meat; from food habits which exclude products rich in iron from the diet; or from poor digestion of such foods due to inadequate gastric secretion. An effective remedial treatment must be based on knowledge of the specific factors producing malnutrition.

In comparison with what we would like to know about nutrition throughout life and its relation to health and its various facets, the available knowledge is meager indeed. However, the results obtained so far demonstrate that nutrition, including nutrition during the period of growth, affects profoundly the processes of aging, terminal diseases, and the length of life itself.—Nutrition Reviews.

OCCUPATIONAL CANCER

Statistical evidence shows that an excessive incidence of a certain type of cancer among members of a given occupational group suggests the existence of an environmental cancer. The rate of incidence among exposed individuals and the length of average latent period depend upon the potency of the carcinogen, duration and intensity of exposure and individual susceptibility. Occupational cancers occur chiefly in males because they have more frequent contacts with industrial carcinogens.

Clinically, a high rate of primary multiplicity is characteristic of occupational cancer. Occupational lesions such as arsenic or tar dermatitis, actinic dermatitis and radiation osteitis are precancerous warnings of industrial cancers to come.

Although industrial cancer is not a frequently recnized type of cancer, it represents a type of tumor which may increase in frequency and importance. Its astute recognition by the medical profession would be an important step in facilitating cancer prevention.—J. Kansas Medical Society.

PROGNOSIS OF SCHIZOPHRENIA*

By M. G. STEMMERMANN, M. D.
and
THELMA V. OWEN, M. D.
Huntington, W. Va.

Satisfaction derived from the practice of any clinical specialty is proportional to the ability of the practitioner to ameliorate or cure disease, as the case may be. Physicians, no less than tax consultants, are flattered by appreciative clients, whether gratitude is expressed by material or less tangible compensation. It is the purpose of this paper to show by material from the literature and nineteen carefully studied cases of our own that persons with schizophrenia can be lifted from the incurable roles to the status of grateful patients. Furthermore, it will be shown that appreciation is based not merely on achievement of health on the premorbid level, but on a much higher one.

A short history to determine the origins from which emanated our previous pessimistic attitude towards this illness follows:

HISTORY

"Mania . . . is intermittent and can be entirely cured by good treatment. Mania terminates in two ways, either by remission or by total cure. The remission is not salutary if it occurs spontaneously."[1] So wrote Aretaeus of Cappadocia. an acute observer, in the first century A. D., although he failed to differentiate "mania" due to schizophrenia, affective psychoses and other mental disorders. Had his observations not been neglected for nineteen centuries, our pessimistic attitude towards psychiatric disorders might have been changed much earlier.

In so far as schizophrenia specifically is concerned, Kraepelin (1855-1926), the meticulous and unimaginative nosologist, further fixed our pessimism by classifying the disorder on the basis of a hopeless prognosis and calling it dementia praecox. We know now that many schizophrenics have only temporary loss of intellect and memory or no loss at all, and that symptoms may appear at any age from childhood to the menopause.

It was Bleuler (1857-1939) who renamed the disorder "schizophrenia" and placed it on the list of curable diseases of man. Yet we are still handicapped by Kraepelin's misguided nosologic efforts. As late as 1935 William Allen White, one of the greatest American contributors to psychiatry, wrote in his standard textbook: "have . . . very distinctly addressed therapeutic efforts, for the most part, been of little avail and the

*From the Owen Clinic, Huntington, West Virginia.

course of the disease has been looked upon, therefore, as beyond control and tending in the direction of deterioration . . . It will probably be some years before any adequate understanding is reached of the therapeutic possibilities of this very malignant type of reaction."[2] If "some years" means more than ten years, Dr. White was unduly pessimistic.

CLASSIFICATION

Although psychiatry is one of the oldest medical arts, it is one of the newest medical sciences and perhaps it may be excusable if its etiologic concepts are obscure, its treatment empirical, and its nosology confused. Because of this, it is necessary, when dealing with diagnosis and prognosis, to define terms. In the following statistical presentation the diagnosis of schizophrenia is based on the A. M. A. Standard Nomenclature which, except for minor differences, is the same as that of the Veteran's Administration.[3] Both classifications are admittedly fallible since in many cases there is overlapping of symptoms. Certainly, aggressive hostility is not confined to paranoid schizophrenia; nor is inappropriate giggling the exclusive province of the hebephrenic. We have previously described the mechanism of aggressive behavior,[4] illustrated by examples from five different patients, only one of whom could be classified as paranoid. In one case of this same group, that of a catatonic who made a complete recovery, inappropriate giggling was one of the outstanding symptoms of her acute illness.

When tabulating results of treatment, it is difficult to find any two observers in agreement. The simplest and most commonly used classification, "recovered", "improved", "dead" or "unimproved" obviously is inadequate. Under "recovered" are listed those "at home" which may mean anything from return to full time premorbid activity to adjustment in a closely supervised, protected situation. "Improved" usually means merely that behavior is less maniacal, although delusions are still prominent.

Our own criteria for "recovered" includes: (1) return to premorbid full time activity, (2) *better* adjustment to home and job than prior to illness and (3) *less* likelihood of "breaking" under emotional trauma than the average person who has not suffered through a mental illness. This type of recovery is in the same category as recovery from a contagious disease such as chicken pox, against which the patient may expect life time immunity.

Patients who can fulfill the first but not the last of the above criteria, we have listed as "remissions". Although many of them do not relapse, there is no assurance that a patient so classified will not. The status of these patients is similar to that of the recovered tuberculosis patient who does well unless subjected to undue stress.

Classified as "improved" are those patients who can fulfill none of the above criteria, yet are able to live in a protected environment and perhaps even hold closely supervised jobs. Relapse of the patients in this group, sooner or later, can be practically guaranteed, just as one can predict recurrence of symptoms in many cases of carcinoma when the primary growth has been incompletely eradicated. All other patients are still hospitalized and have therefore been classified as "unimproved", although abnormal behavior may be much less obvious than on admission.

MATERIAL

With the institution of convulsive therapies (insulin 1933, metrazol 1935, electric 1939) the length of the hospitalization period has been shortened and the number of patients discharged home has increased. Hinko and Lipschutz,[5] in a series of 746 cases (90 per cent schizophrenics), found that the average length of hospitalization of

Table 1

What is the patient doing one or more years after admission?

Source	No. Patients	Observation	RESULTS			RECOVERY CRITERIA
			Recov.	Improv.	Dead or Unimprov.	
A[8]	100 M	2-8 yrs.	38%	19%	43%	At home; much improved or better.
B[9]	100 F	1½-6 yrs.	43%	24%	33%	At home; much improved; some, better than before.
C[10]	563	5 or more yrs.	34%	38%	28%	Complete return to premorbid activity.
D[11]	214	5-7 yrs.	49%	22%	29%	Not hospitalized.

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Table 2

WHAT HAPPENS TO THE SCHIZOPHRENIC PATIENT?

Case	Age	Sex	Diagnosis*	Admission†	Hosp.	Disch.**	Disch. Result	Present Status	Disch. Follow-up	Total Observ.	Remarks
1	20	M	Simple	1st	7 mo.	Triol Visit	Impraved	Improved	4½ yeors	5 years	Employed. Supervised.
2	17	F	Cotatonic	1st	13 mo.	R	Recovered	Recovered	3½ years	4½ years	Employed. Unsupervised.
3	29	F	Catotonic	1st	2 mo.	AA	Remission	Remission	4 yeors	4½ yeors	Employed. Unsupervised.
4	50	F	Poranoid	1st	5 mo.	T	Unimpraved	Unimproved	4½ yeors	5 yeors	Hospitolized.
5	38	F	Paronoid	1st	1 ma.	T	Unimproved	Unimproved	3½ yeors	4½ years	Hospitalized.
6	32	M	Poranoid	1st	3 mo.	AA	Improved	Improved	1 year	2 yeors	Employed. Unsupervised.
7	36	F	Poranoid	1st	4 mo.	AA	Unimproved	Unimproved	2 yeors	3 years	Hospitalized.
8	32	F	Simple	2nd	11 mo.	T	Improved	Improved	3 years	4 yeors	Dependent. Supervised housework.
9	49	F	Paronoid	4th	1 mo.	T	Unimproved	Unimproved	3 years	4 yeors	Hospitalized.
10	19	F	Simple	1st	17 mo.	Triol Visit	Remission	Improved	2½ yeors	3¾ yeors	Dependent. Supervised. (Nurse's aide.)
11	16	F	Cototonic	1st	4 mo.	T	Unimproved	Impraved	1 year	2 yeors	Dependent. Supervised housework.
12	26	F	Catotonic	1st	3 ma.	AA	Remission	Remission	2¾ years	3 yeors	Employed. Unsupervised.
13	33	F	Catatonic	1st	7 mo.	R	Recovered	Recovered	2¾ years	3¼ years	Employed. Unsupervised.
14	34	F	Simple	1st	12 mo.	T	Unimproved	Improved	1 year	2 yeors	Dependent. Supervised housework.
15	22	F	Simple	1st	5 ma.	AA	Improved	Improved	1½ years	2 years	Dependent. Supervised. housework.
16	28	F	Catatonic	1st	7 ma.	Trial Visit	Remission	Recovered	3¼ yeors	3¾ years	Employed. Unsupervised.
17	28	F	Cototonic	1st	7 mo.	AA	Remission	Remission	1¼ years	1¾ yeors	Employed. Unsupervised.
18	23	F	Catotonic	3rd	13 ma.	Trial Visit	Remission	Remission	1 year	2 yeors	Employed. Unsupervised.
19	40	F	Simple	1st	2 mo.	AA	Improved	Improved	1 year	1¼ yeors	Employed. Unsupervised.

*Hebephrenic schizophrenia hos been omitted from this study. First, we hove had no patients so diognosed. Second, there is strong evidence that this conditlon is the end result af long stonding, inodequately treated catotonic or simple schizophrenia.

**AA—Against advice, T—Transfer, R—Regulor. †Admission to any mental hospital.

untreated patients was 20.4 months, that of treated patients, thirteen months. Of untreated patients, i. e., spontaneous cures, 16.2 per cent were paroled; of treated patients, 56.6 per cent were paroled. Many other comparative studies indicate similar findings.[6,7]

This is not unencouraging, but hardly answers the all important question: What is the patient actually doing one or more years after his first admission to a mental hospital? A few answers are tabulated in table 1 which refers only to patients who have received one or more forms of convulsive therapy. The great difference in recovery rates shown by sources C and D obviously exemplifies differences in "recovery" criteria. We may conclude, however, that from one-third to one-half of the number of scizaphrenics admitted to mental hospitals and treated with convulsive therapies plus other traditional measures will recover sufficiently to be discharged.

Two further questions remain: Are these patients, although recovered, still a "little queer"? How can we improve the recovery rate? Because of difficulties in following post-hospitalization careers, adequate reports in the literature are not available. In an attempt to answer these questions, we have carefully followed nineteen schizophrenic patients from one and one-fourth to five years after admission, one to four years after discharge. All patients were hospitalized on a voluntary basis from one to seventeen months; of the large number of "discharges against advice", seven are directly attributable to the voluntary status. To this number should be added two "trial visit" patients for whom outpatient treatment was advised, but who failed to keep their appointments. It is extremely likely that seven of those discharged improved or in remission could have achieved a recovered status had they availed themselves of adequate treatment. Case 16 accomplished the transfer from remission to recovery by outpatient guidance while on trial visit. Case 10 has slipped from remission to improved through failure to carry on as an outpatient.

Final results in the group reveal that three patients (all catatonic) have recovered; four (all catatonic) are in remission; eight (six simple, one catatonic, one paranoid) are improved; four (all paranoid) are unimproved. Four careers typical of the foregoing results illustrate the basic characteristics influencing prognosis. These careers could be duplicated in essentials by hundreds of other case studies.

Case #2. Catatonic schizophrenia. Recovered. Employed; unsupervised. A 17 year old female high school student was admitted acutely ill: hyperactive, delusional, hallucinating, completely out of contact with her environment. For the previous six months the parents had noticed a personality disturbance, when she had changed from an obedient, friendly, quiet child to an arrogant, temperamental one. For some weeks she had spent nights and days roaming the streets; for some days she had refused to eat or drink. Nine months after admission, following electric convulsive therapy, modified insulin, and occupational therapy, she was apparently well and began spending weekends at home. At this point she could have been discharged in remission. However, while she was apparently well and her behavior entirely normal, she had as yet no insight into the dynamics of her illness nor reserve emotional resources with which to withstand future environmental stresses. Basic insight was given during the next four months by means of individual psychotherapeutic interviews. Study of her subsequent career has justified her "recovered" status. She completed high school and apparently made a better adjustment than before her illness, as she was voted the best citizen in her class by her contemporaries. She then worked part time in a department store and attended college part time. She married and continued working until five months before delivery, when she was obliged to stop because of a placenta praevia. Neither the return to the environment causative in her illness, nor the emotional trauma connected with a complicated pregnancy has had deletorious effects on her emotional stability.

Comment.—Three factors are responsible for the recovery of this patient: (1) youth, (2) relatively prompt, active treatment and (3) maintenance in a protected hospital situation with gradually increasing responsibilities, until she had acquired sufficient emotional reserves to handle any responsibilities the future might hold for her. Hospitalization could have been shortened had she spent in active treatment the months she had wasted roaming the streets. With four months' intensive psychiatric guidance, she was able to cope with her difficulties. Had she received this guidance at seven instead of seventeen, she might very well have completely avoided mental illness. From the prognostic standpoint cases 13 and 16 are similar. Both have maintained their stability through experiences that previously might well have "broken" them.

Case #3. Catatonic schizophrenia. Remission. Employed; unsupervised. A 29 year old housewife was admitted acutely ill, in a state similar to that of case 2. For one year prior to admission the patient's usual good temper had been replaced by restlessness, outburts of temper, and insomnia. Symptoms increased until two

weeks before admission when she entirely lost self-control. After two months' treatment with electric convulsive and occupational therapy, her behavior was entirely normal and the patient and her husband decided she was well. For four and one-half years she has adequately assumed the responsibilities of her home and three children under circumstances essentially the same as those that existed prior to her illness. We consider her in remission rather than recovered because faulty habits of thinking are unchanged and she is no better adjusted than before her illness. This is illustrated by a recent letter in which she reports: "I left your clinic for the reason I was in such a hurry to get back to my children . . . I suppose you thought I didn't like you the way I wanted to rush off before I finished my course of treatments for my nerves . . . I am a person of very few friends. Most people to me are very boring. That isn't a very good attitude to take toward people, is it? . . . While you were summing up my personality, I was doing pretty much the same for you . . . although I would have liked to have been well enough to have a lot of long friendly chats . . . I'm very much in need of a few friends who understand me in the form of women (because most women just don't like me) and I know it . . . I don't have a personal friend. I have to live a very quiet life; I can't stand noise and confusion. I like to read real interesting books and chat with other people who are interested in Science and Religion and your branch of work. I do get so lonely since my children are growing up and they have interests of their own."

Comment.—Relatively early, active treatment resulted in prompt remission, but this patient, who refused additional psychiatric guidance, is no better able to withstand emotional trauma than she ever was. To date she has remained well only because her life has flowed fairly smoothly. The crucial time will come later when she discovers her children no longer need her and, in fact, that she is unnecessary to anyone's happiness. At this time when she becomes ill, she will be labeled "involutional".

Case #1. Simple Schizophrenia. Improved. Employed; supervised. A 20 year old male college student was admitted for the summer months because of unprovoked temper tantrums when he would destroy his personal clothing and books, and occasional episodes of diurnal and nocturnal wetting. All his life he had been excessively "dreamy", dependent, and lacked normal emotional tone. He had been given a neuropsychiatric discharge from the Navy after one week's service, one year before admission. Both parents had committed suicide. His grandfather, two great aunts and an uncle were psychotic. All other known relatives are maladjusted. Following the initial admission, he was followed closely for a two year period as a full time hospital patient, part time patient commuting to college, paroled patient, and part time hospital employee. At various times he received electric convulsive therapy, modified insulin, music and occupational therapy. He was able to control his temper tantrums and wetting, but was unable to complete college and has shown no essential change in his basic personality pattern. At present he is partially self-supporting as a pin boy in a bowling alley, but all aspects of his daily living require close supervision.

Comment.—Two factors are responsible for failure to halt the progress of this patient's disease: (1) length of illness, probably life-time, and (2) hereditary factors. Unless patients with this basic personality pattern can receive intensive guidance in early childhood, a large percentage will be unable to make a completely satisfactory life adjustment. This patient's illness, while less dramatic than that of cases 2 and 3, actually is much more malignant. If sufficiently protected he will remain a pin boy or its equivalent for the rest of his life. If death or other catastrophe removes his protection he will ultimately spend his days in a mental hospital, unmoved and unmoving, wrapped in his dream world. more vegetable than man.

Case #4. Paranoid Schizophrenia. Unimproved. Hospitalized. A 50 year old housewife and former teacher was admitted acutely ill: combative, mute, with homocidal tendencies based on the delusion that many people were trying to harm her. She had been "peculiar" for six years, gradually becoming worse during the previous five months. Physically, her condition was poor: diabetes, nephrosclerosis, albuminuric retinitis, hypertension. Physical rehabilitation by conventional methods and psychiatric treatment by electric convulsive therapy, hydrotherapy, and occupational therapy were instituted. Retinal and urinary findings became almost completely normal and she was maintained sugar-free on eighteen units of protamine zinc insulin daily. Mentally, she improved sufficiently in that she was able to "cover up" her delusional thinking and conduct herself acceptably. However, during five months' hospitalization her behavior frequently slipped back to belligerency and at no time did she relinquish the idea that the world was against her. She was transferred to another private hospital with the hope that a change in surroundings would help change her attitude. Following transfer she became worse and was sent to a state hospital for custodial care with a hopeless prognosis. She is still hospitalized, five

years after the first hospitalization, eleven years after appearance of first symptoms.

Comment.—Four factors were responsible for the poor outcome in this case: (1) length of illness before treatment was begun, (2) age, (3) poor physical condition with probable organic cerebral damage and (4) basic, inherited personality structure. Through ignorance this patient was denied the benefits of psychiatric experience for a long period of time, when treatment might well have mitigated the effects of the fourth factor. When treatment is postponed until late adult life after habits of thinking have become rigid, persecutory delusional material is almost impossible to change, at least by our present methods of attack.

DISCUSSION

Our studies of schizophrenia indicate that during the first "break", two to three months' active treatment including convulsive therapy, can arrest almost all cases of catatonic schizoprenia. At the end of this period the patient, superficially, appears as well as he had ever been. His behavior has returned to the premorbid level; his thinking is no longer distorted by delusions and hallucinations. He can be discharged and, unfortunately, because of bed shortages and family importunities, he frequently is. However, he can be discharged only with the full knowledge that at best he will be "a little queer" and react excessively even to minor disappointments. At worst he will "break" again. He still has no insight into the causes of his illness, has not learned how to cope either with annoyances or disasters, and does not know how to utilize his assets constructively. Unless he learns these things, he will be as unhappy as case #3, although he may show no obvious signs of disease.

The length of time required for re-educational treatment will vary from three to twelve months depending upon: (1) age, (2) I. Q. and (3) environment to which he will be discharged. Most of these months should be spent in the hospital where the patient can be given gradually increasing responsibilities. If all catatonic schizophrenics could receive such a re-educational program all would recover completely, and for life.

The onset of catatonic schizophrenia is relatively abrupt, dramatic, typically maniacal, and the prognosis with early and adequate treatment is very good. The problem in simple schizophrenia is more difficult. The onset here is in childhood, and it is almost impossible to determine exactly when the first instances of abnormal behavior occurred. These patients have always been "different"; the illness usually has become firmly entranched before treatment is begun; the child will not "outgrow it" nor the adult "muddle through". The outlook is, therefore, correspondingly poor. Convulsive therapies are less useful in this group and treatment must depend primarily on a re-educational program. This necessarily requires a period of hospitalization longer than that required for the catatonics, a period that is rarely tolerated by either the patient or his family. In our group no simple schizophrenic acquired a recovered status, because all were either discharged against advice or transferred to another hospital. None has since achieved complete recovery. Until ways can be discovered to increase the emotional tone of these patients, to be effective, treatment must begin at least in adolescence, preferably childhood. In adult life we can improve, but we cannot cure.

Like simple schizophrenia, paranoid schizophrenia is also a long standing illness before treatment is sought, and with better reason. The simple schizophrenic usually has been innocuous but relatively ineffectual. The paranoid, however, usually has been effective and ambitious. By an efficient work life he keeps well covered the fact that he feels unappreciated and misused. There are many reasons why the relatives of the simple schizophrenic should realize early in the patient's life that he is maladjusted. Relatives of the paranoid may well be deceived by this patient's behavior. Even if not deceived, they must be unusually alert strategists to win the battle against the patient's resistance to treatment. Prognosis, therefore, is extremely poor. It may be possible to help the patient "cover up" his fixed delusions of many decades' duration. It is rarely possible to destroy them.

CONCLUSIONS

1. A definitive classification of the condition of schizophrenic patients on discharge has been discussed, and categorized as follows: recovered, in remission, improved, unimproved. Our criteria for "recovered" are much more strict than those in the literature.

2. If all psychiatric treatments are made available, it is possible for all catatonic schizophrenics to achieve a recovered status indicating that they are better adjusted and more stable than prior to illness. None of our patients discharged as "recovered" has relapsed.

3. Unless brought for treatment at a much earlier age than usually is the case, even with all present methods, simple schizophrenics can reach a remission or improved status, but rarely a recovered one.

4. The prognosis in paranoid schizophrenia is even poorer than that in simple schizophrenia, again not only because of length of illness, but also because there is no effective means of destroying the emotionally charged, fixed delusions of those in this group. Paranoid schizophrenia constitutes a real challenge to psychiatry.

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AIR POLLUTION A COMMUNITY PROBLEM

Air pollution is a contentious subject. It stems from a basic conflict between an aroused population demanding a decent living environment and the inherent right of industry to unrestricted operation within the limits of its properly zoned property. The situation is aggravated by lack of information and poor public relations on both sides. It is further aggravated in many communities and at various times by the publication of sensational and alarming statements authored by self-seeking and irresponsible politicians or professional men who ought to, and possibly do, know better.

Air pollution is not a new problem; in fact it is a very old one. However, it is during the past few decades that it has been brought into sharper focus because of the heavier concentration of industry in many areas. The last war has also been the cause of the industrialization of many areas formerly devoted to residence or recreation resorts, and their people are unused to industrial pollution. All these factors have combined to create the problem facing us today. It is a complicated problem, and it will be solved only if patience, perseverance, ingenuity and understanding are exercised. The solution cannot be arrived at quickly, and the millennium cannot be expected; but, likewise, there is no call for pessimism.—H. G. Dyktor in Industrial Medicine and Surgery.

SARCOIDOSIS

Few diseases have attracted the interest of specialists in so many fields as has sarcoidosis. The range of clinical signs of the disease is now fairly well recognized, and it is known that the widely distributed lesions share a common pathology.

Histologically sarcoidosis is characterized by focal proliferation of epithelioid cells, among which giant cells are commonly found. Central necrosis and caseation do not occur, and in the chronic stage hyalinization and fibrosis take place.

The relationship between sarcoidosis and tuberculosis has caused much controversy. Some believe that the frequency of negative tuberculin tests in cases of sarcoidosis and histological similarity between the two diseases indicate a direct relationship—the clinical and pathological differences being explained by variations of the immunity reactions of the body to infection with the tubercle bacillus.

The other view, that sarcoidosis and tuberculosis are distinct diseases, is supported among other reasons because tubercle bacilli are not found in the lesions of sarcoidosis and the disease cannot be transmitted to animals.

The recent discovery of a tuberculin-neutralizing factor in the serum of patients with sarcoidosis, the suggestion that the inclusion bodies of sarcoidosis are related to an allergic hyperglobulinosis, and the recognition of cases of erythema nodosum with radiological evidence of sarcoidosis within the thorax, while of great interest, have by no means settled the question.

The treatment of sarcoidosis has hitherto been unsatisfactory. Although many patients with pulmonary sarcoid suffer very little disability there is always the possibility that fibrosis, emphysema, and respiratory insufficiency may develop. Treatment is thus of great importance.

Even if it is assumed that sarcoidosis is a manifestation of tuberculosis it would not be expected that streptomycin would be of value in a disease with lesions which are predominantly proliferative. Such scanty trial as has been made with this drug indicates that it is of no value in the disease.

Dr. Scadding has treated nine cases of pulmonary sarcoidosis with calciferol, using a dosage similar to that found effective in the treatment of lupus. Three of the patients were remarkably intolerant to the drug, but the six patients who were able to take full doses all improved.

An exact interpretation of these findings cannot be given, and little can be deduced from so small a number of cases, but it seems that the use of calciferol in sarcoidosis is worth further clinical trial. Not only might it provide a useful and simple method of treatment, but it may also throw further light on the unsolved problems of this disease.—British Medical Journal.

AVERAGE HOSPITAL STAY

The average hospital stay is now more than two-and-one-half days shorter than it was 10 years ago, according to the Bulletin of the Hospital Council of Greater New York.—R. N.

HYPERTENSION NOT A DISEASE

Hypertension is today's fancied-up synonym for high blood pressure. The latter term came into medical use in the early 1900's when the first attempts were made to utilize clinically the blood pressure measuring devices invented by the physiologists *circa* 1850. Hypertension is not a disease, even though some health authorities permit its inscription as a cause of death. It appears as a sign or symptom of disease,—but it is never anything more, clinically.

The high-priced books I carry on my shelves tell various stories: The Germans say that "arteriosclerosis is a constitutional disease"; the French, that "the arterial lesions in alcoholism may be taken as a type even though plumbism, gout, diabetes, old age, toxins, and the vegetable or mineral poisons may give rise to them."

The British believe that "arteriosclerosis is the product of our high pressure life and too much alcohol, work and worry." With this the Americans agree, adding that "arteriosclerosis is the product of hypertension and/or results from a too rich protein diet." The volumes open and close with no defined statement of what might bring about vascular disease, thus leaving the practitioner to a therapy only ameliorative.

To put it flatly, no kind of systemic intoxication, however bad for the vascularly afflicted, has anything at all to do with its initiation. The recited elements (including "heredity") would bring down upon the victim a blood vessel breakdown generalized in character; actually it is always local in type.

To teach this fundamental principle of pathology I call the attention of my students to a cartoon in which a doctor is facing an old man with a bandaged right foot. "The pain in your foot is the consequence of your age," says the doctor; and the patient answers: "Nonsense, my left is just as old and it does not hurt me."

Localized disease springs solely from localized cause, —inheritance, old age, alcoholism, and every other form of systemic intoxication cannot therefore be responsible. Had the old man's foot been tread upon, that could be the explanation; but in the absence of trauma, only one pathological mechanism remains to affect one side of a body and not its opposite; or one spot only in any uniform tissue and not the rest. This is the appearance of a locally active insultant,—origin of which we know only as the product of microorganismal life sown into that part.

Vascular disease has never been produced experimentally through any kind of general intoxication; it succeeds only upon the distribution of proper microstream.—Martin D. Fischer, M. D., in New Orleans Med. and Surg. Journal.

RELATIVITY OF HEALTH

For centuries doctors have been indoctrinated with the concept that the primary functions of the physician are to discover, identify and treat disease. The inadequacy of this attitude is apparent today, and to perpetuate it is to retard the progress of medical science and practice.

Health is by no means the mere absence of disease. Being relative, it can always be improved. While no one attains truly ideal health, perfection in health, like infinity, is nevertheless approachable. The potentialities of a healthy, vigorous and mature mankind, largely unexplored as yet, are nevertheless obviously immense.

Perhaps geriatric medicine more than any other area of medical practice emphasizes the relativity of health. In later maturity, responsibility for health rests first and foremost upon aging persons themselves. Medical science and practice can give health to no one, nor can medical service schemes. Health, like respect, must be earned. Nevertheless, there rests upon medical science and practice the responsibility to discover the causative factors responsible for premature depreciation and the means of their prevention. Also, there is the obligation to guide and advise those who endeavor to keep well.

By focusing their concern upon the construction of greater health of the individual as a whole, rather than merely upon the amelioration of some disorder, clinicians might well enhance tremendously their therapeutic and preventive accomplishments. The physician-patient relationship, in all its individual, personal aspects, has a role in constructing health that has long been neglected. Even with the broader concepts of today, there is great need for better comprehension of the positive meaning of health and for clinical methods of evaluation and measurement of health, as contrasted with the identification of disease.—J. Florida Medical Assn.

REHABILITATION PAYS DIVIDENDS

Naturally, the purpose of rehabilitation is to make people self-supporting within the limits of their disabilities. There are many reasons, economic, social and spiritual, why it is desirable that the handicapped should not be totally dependent upon others. They, themselves, desire self-sufficiency; and the fact that they may attain this is evidenced by the work of the Federal Office of Vocational Rehabilitation. During the fiscal year 1949, 58,000 persons were rehabilitated. Seventy-four per cent were unemployed at the beginning of rehabilitation; 100 per cent had jobs when it was completed. The wages paid to these people reached $94,000,000, or almost 5 times the previous earnings of the entire group.

It should be remembered that the expense of vocational rehabilitation is not a continuing burden upon tax-payers. Once it is paid, the cost becomes merely a matter of history. What continues is the increasing economic worth, the improved wage-and salary-earning power of the beneficiaries.

Medicine has always been an individualistic profession. Indeed, it is about the only remaining individualistic profession in a cooperative world. But that successful rehabilitation is now a job for the physician only should be obvious to anyone who gives the subject serious consideration. It requires, and should receive, the cooperative assistance of many people endowed with a variety of skills and experience in many fields; in a word, it demands team-work. In this teamwork the physician should play an important part, for, to him, the sick and the injured look for help and guidance.—Rhode Island Medical Journal.

The President's Page

The attempt of the eager beaver bureaucrats in Washington to insert a wedge in the door leading to socialized medicine was killed off by the decisive vote of 249 to 71 in the House of Representatives on July 10.

The vote was on the question of approving House Resolution 647, calling for the rejection of Reorganization Plan No. 27, and the result was directly contrary to the recommendations of the House Expenditures Committee.

It is conservatively estimated that four or five hundred telegrams and letters protesting Reorganization Plan No. 27 were sent out of West Virginia to our Representatives in Washington shortly before the vote in the House. These wires were sent by doctors, dentists, lawyers, and other business and professional men and women who are fighting the whole idea of socialized medicine.

As this page is being written, we understand that Congressmen E. H. Hedrick, John Kee, and H. M. Burnside voted with the overwhelming majority of the members of the House to kill Reorganization Plan No. 27. Congressman Robert L. Ramsay and Cleveland M. Bailey are recorded as voting with the minority. Congressman Harley H. Staggers is not recorded as having voted. At least we have a little better than a fifty-fifty break in the recorded vote of our Representatives in the House.

On behalf of the thousands upon thousands of West Virginians who have opposed and are opposing the regimentation of the medical profession, we extend a vote of thanks and deep appreciation to Congressmen Hedrick, Kee, and Burnside for lining up on the side of forces which are making a determined fight against the plan of the pitifully few but powerfully vociferous bureaucrats who are trying to inflict the welfare state upon the people of this country.

C. E. Watkins

President.

West Virginia Medical Journal

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The West Virginia State Medical Association
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OUR ANNUAL MEETING

All arrangements had been completed for the 83rd annual meeting of the West Virginia State Medical Association at White Sulphur Springs as copy for this issue of The Journal went to the printer (July 19). There had been but one change in the program. The date for the appearance of Dr. Elmer L. Henderson, president of the American Medical Association, had been changed from Friday evening, July 28, to Thursday evening, July 27. The presidential address to be delivered by Dr. Charles E. Watkins was changed from Thursday evening to Friday evening.

There had been unusually few cancellations of reservations by members of the West Virginia State Medical Association. In each instance up to the middle of July, rooms for these cancellations have been taken up by other members who have been unable to obtain rooms at The Greenbrier.

The meeting this year has all the ear-marks of being one of the very best ever held at The Greenbrier, or, for that matter, at any other place in West Virginia. Every possible effort has been made by the Program Committee to provide a program that will interest all members. There will be a heavy attendance by doctors from nearby cities who, on account of lack of accommodations, will return home each evening.

The main dining room will be used for the annual banquet. Last year the auditorium was jammed to the doors, with over 500 in attendance at the banquet. More space can be provided by using the main dining room.

We again congratulate everybody who has had anything whatsoever to do with arrangements for the convention. We believe that every doctor attending the general sessions will be immensely pleased with the varied program that has been arranged.

IS ENOUGH ENOUGH?

Another powerful blow against socialized medicine was struck in the House of Representatives on July 10 when that body approved a resolution rejecting the much publicized Reorganization Plan No. 27. The vote was a thumping 249 to 71.

The vote of the West Virginia delegation in the House was split 3-2, with one member not voting. By voting approval of the resolution to reject, Congressmen E. H. Hedrick, John Kee, and H. M. Burnside lined up with the forces opposed to Reorganization Plan No. 27, which, like Resolution Plan No. 1, defeated by the Senate in August, 1949, would have given complete government control over health and medical services.

Congressman Robert L. Ramsey and Cleveland M.. Bailey voted with 69 other Congressmen in opposing the resolution to reject the plan. The Congressman from the Second District, H. H. Staggers, was not recorded as voting.

The House vote for the resolution to reject was 31 more than the required constitutional majority of 218.

We are just wondering if enough is really enough for the small group in Washington that has been trying for several months to force this undesirable legislation to a successful vote in Congress. Certainly, the medical profession should not take too much for granted. There is such a thing as being "lulled into a sense of false security." We should keep our medical powder dry. We applaud the three Congressmen from West Virginia, representing the three essentially southern districts, for having the courage to oppose an administration-backed plan that undoubtedly constituted considerably more than a mere sample of what might be expected from government control of any of the professions.

THEY SAY

They say the medical profession is monopolistic, that its selfish interests are unfair to other schools of healing; that government control is needed to assure the great American public adequate medical care.

What do they mean, selfish, when they themselves admit that we have added ten years to their life expectancy in the last twenty-five years?

What do they mean, talking about government control, when 40,000 doctors and more volunteered to enter the service of our country, where they established the most inspiring record of military medicine ever known by any nation at war?

What do they mean, the public isn't receiving medical care, when advancements are announced every week? These were discovered and tested and proved by the medical profession without government help or control. And they are used to serve the public. . . .

Just what is selfish about saving life? What is dangerous about making people well who are sick? What is monopolistic about requiring a high standard for such work? Or don't we understand those things as we should?—Sedgwick County Medical Society Bulletin.

WHERE WOULD YOU RATHER BE?

The *Wall Street Journal* recently took an unusual approach to the problem of socialized medicine. It pointed out that when new "miracle" drugs—such as the sulfas, penicillin, cortisone, and so on, are first discovered their cost is extremely high. Then the detractors of American enterprise say, "Science is discovering wonderful things but the private capitalistic system is keeping them out of reach of the people. So we ought to have socialized medicine or government pill subsidies or government planning for the chemists—or whatever is the speaker's pet project."

However, the paper went on, "These misty-eyed sociologists quickly drop the matter as soon as the chemical industry has cut the problem down to size. They point the finger of scorn when penicillin sells wholesale at $20 a 'dose' and forget the matter when it shortly comes down to 4 cents a partaking . . ."

If anyone honestly thinks that the cause of healing, in any of its many manifestations, would be advanced by socialized medicine or government domination of the nation's medical personnel and facilities, he is blind to the facts. Progress, in any direction, flourishes in an air of freedom—not in an atmosphere of red tape, bureaucracy, political management and government monopoly.—Clarksburg Telegram.

SCIENTIFIC EXHIBITS WORTH WHILE

The scientific exhibits arranged by the Southern Medical Association always draw well at any annual meeting. They are usually interesting and instructive and well worth the time any doctor has to spend in visiting this part of the displays.

West Virginia doctors in the past have furnished quite a number of interesting scientific exhibits for annual meetings of Southern Medical. We hope that this state will be represented this year at the annual meeting in St. Louis, November 14-16.

Southern Medical draws an unusually large delegation from West Virginia at all annual meetings. It is hoped that at least two or three scientific exhibits may be arranged by state doctors who expect to make the trip to St. Louis in November.

A COMMITTEE OF ONE

The physicians of the United States cannot compete against the government in terms of spending, but we can compete in other ways. Our position represents the democracy that made our country great. Our profession reaches the people individually face to face in conversation, and finally we have with us a great throng of other business and professional persons who also believe as we believe.

If we tell our story cleary and coherently to the people we meet, Mr. Ewing's pamphlets, his newspaper and radio releases will fail to change the the public's mind. If we explain in clear language the advancements made by medicine and how the death rate has been reduced and the average life expectancy extended under a system of free enterprise the public will be less intrigued by systems of medical care borrowed from decadent and broken European nations.

If we appoint ourselves each as a committee of one to defend the freedom our fathers left us, and if we work at this diligently enough, it cannot be taken away. We approach this battle as citizens of this great nation and combine our strength with that of thousands of other persons to save democracy within our country, to prevent a small handful of misguided men from trading the hard-earned liberty we have, our birthright, for a mess of pottage that is called security. —Haddon Peck, M. D., in J. Kansas Med. Soc.

RELIEF FOR ITCHING DERMATITIS

It is reported that research is now in progress with ointments containing the antihistaminics. In one group of 85 cases of various forms of itching dermatitis, 51.8 per cent obtained complete relief and 21.1 per cent partial relief through the use of such preparations. The best results were found in neurodermatitis and contact dermatitis.—Arizona Medicine.

GENERAL NEWS

GOVERNOR PATTESON PAVES WAY FOR CREATION OF STATE HEALTH COUNCIL

Governor Okey L. Patteson has named a health planning committee composed of twenty-two business and professional men and women of the state. The official name of the new group is "West Virginia Citizens' Health Planning Committee."

Dr. W. J. Scarborough, of Buckhannon, president of West Virginia Wesleyan College, heads the committee, and the other members are as follows: Mrs. C. D. Ellifrits, Elkins, president, West Virginia Congress of Parents and Teachers; Dr. Deane F. Brooke, of Beckley, UMW Area Medical Administrator; Dr. John M. Slack, of Morgantown, professor and head of bacteriology at West Virginia University School of Medicine; Dr. John W. Davis, of Institute, president of West Virginia State College; Mrs. G. W. Myers, of Shepherdstown, president, West Virginia Farm Women's Council; Dr. Paul L. McCuskey, Parkersburg, president, Parkersburg Academy of Medicine; Miss Martha Woodell, Clarksburg, executive secretary of the Harrison County Tuberculosis League; Mrs. Dale Thomas, Charleston, immediate past president of the State PTA; Sattis Simmons, Ripley, editor of the *Jackson Herald;* Mrs. Sam Hanna, Renick; Dr. John C. Batten, Pine Grove; Dr. Raymond M. Sloan, Barboursville; C. A. Duffield, Jr., Sutton; Mrs. Arch Paul, Sr., Triadelphia; Edmund H. Browning, Logan; C. R. Stahl, Mount Hope; Essie E. Bailey, Princeton; George Bryson, Welch; Melvin Snyder, Kingwood; H. A. Stroud, Fairmont; and, John C. Ailes, Romney.

The committee has been appointed by the Governor as an outgrowth of a meeting held in Charleston in December, 1949, which was arranged by Doctor Scarborough and Dr. Richard Smith, supervisor of the Mountain Mining Mission, Morgantown. At that meeting, ways and means were discussed for stimulating interest in improved health conditions.

After this initial meeting, a follow-up conference was held in February, 1950, at the offices of Dr. N. H. Dyer, state director of health. Representatives were present from the United States Public Health Service, American Public Health Association, National Health Council, United Mine Workers Health and Welfare Fund, and the West Virginia State Medical Association.

The committee, through the state health department, recommended that Governor Patteson invite a group of responsible persons in West Virginia to constitute the nucleus of a larger group to include citizen and agency representatives.

The broad functions of the new committee have been outlined as follows:

Coordinate as far as possible the thinking and planning of all organizations concerned with the public health;

Work to prevent overlapping and duplication;

Study health needs of communities through appraisals, inventories and other fact finding activities;

Develop community health programs related to those needs and facilities;

Stimulate public interest in health problems and their solution;

Express itself with strength and authority on matters of all health legislation; and,

Render to members common services in the field of statistics and research and community health education.

It is thought by many that this committee will develop into a real state health council, the need for which has been discussed in conferences between public health workers, representatives of the West Virginia State Medical Association, and various other groups interested in public health needs.

UROLOGY AWARD

The American Urological Association is offering an annual award of $1000.00 (first prize of $500.00, second prize $300.00, and third prize $200.00) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Palmer House, Chicago, Illinois, May 21-24, 1951.

Full particulars may be obtained by writing to the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey.

DR. B. S. BRAKE NAMED HEALTH OFFICER

Dr. Blonda S. Brake, of Clarksburg, has accepted appointment as health officer for District No. 3, comprised of Mason, Putnam, Jackson and Roane counties, with headquarters at Pt. Pleasant. The appointment was made by Dr. N. H. Dyer, state director of health.

Doctor Brake has practiced his profession in Clarksburg for the past twenty-eight years, and has served as president, secretary, and treasurer of the Harrison County Medical Society.

CRIPPLED CHILDREN'S SOCIETY NAMES DIRECTOR

Mr. Edward J. Aud, native of Oklahoma, has been appointed the first executive director of the West Virginia Society for Crippled Children and Adults. The appointment, which is effective August 1, has been announced by the president, Mrs. Fred B. Watkins, of Charleston.

Mr. Aud received his A.B. degree from Northwestern University, and his M.A. degree from Oklahoma A. & M. He has served for four years as a vocational counselor and district manager with the rehabilitation division of the Oklahoma Board for Vocational Education.

DOCTOR PRIDE REAPPOINTED TO MLB

Dr. Cecil B. Pride, of Morgantown, has been reappointed by Governor Okey L. Patteson, as a member of the Medical Licensing Board. He will serve until 1955.

NEW MEMBERS OF STATE MEDICAL ASSOCIATION ELECTED SINCE JAN. 1

The following is a list, by component societies, of new members of the West Virginia State Medical Association, elected since the publication of the 1950 roster:

Borbour-Rondolph-Tucker

Harley, John B. — Terra Alta

Boone

Curry, Wyson, Jr. — Madison
Love, William C. — Sharples
Novey, Peter J. — Nellis
Silipo, Anthony A. — Prenter

Cobell

Clemmons, Howard M. — Huntington
Hibbard, Robert William — Huntington
Mackey, William K. — Huntington
Peck, Frank McDonald — Huntington
VanDenBosch, W. R. — Huntington
Van de Wetering, Robert J. — Huntington

Central West Virginia

Almond, Harold D. — Buckhannon
Fidler, A. K. — Rock Cave

Eastern Ponhondle

Marshall, H. T. — Martinsburg
McCune, William R. — Hedgesville

Fayette

Gardner, Charles K. — Oak Hill
Guerrant, John S. — Beards Fork
Peck, Clemmar M. — Powellton
Saver, Gordon — Gauley Bridge
Smith, Roger F. — Gauley Bridge
Snell, Frank B. — Montgomery
Stallard, C. W., Jr. — Alloy

Greenbrier Volley

Compton, John W., Jr. — Ronceverte
Hall, William Thomas — White Sulphur Springs

Horrison

Walker, W. N. — Bridgeport

Kanawha

Blagg, John S. — South Charleston
Claro, Joseph J. — Clendenin
Crites, John Lee — Charleston
Gibson, Robert E. — Charleston
Harper, C. A. — Clendenin
Herman, Leon — Widen
Hull, Ernest Q. — Charleston
Snodgrass, H. W. — Miami, Florida
Wallace, Richard C. — St. Albans

Logan

Ashcraft, John R. — Holden
Bevaequa, W. A. — Stirrat
Brown, Lee B. — Lorado
McReynolds, Charles R. — Man
Mullins, David W. — Logan

McDowell

Jackson, R. D. — Welch
Nicgorski, Eugene H. — Filbert

Mercer

Champion, J. P. — Princeton
Combs, R. G. — Bluefield
Copenhaver, W. E. — Bluefield
Lee, Parker Hall, Jr. — Bluefield
Shafer, W. A. — Bluefield
Troup, H. E. — Bluefield

Mingo

Donovan, Joseph — Delbarton
Harvey, David C. — Delbarton
Ison, Harry — Red Jacket
O'Boyle, C. Patrick —
Smith, W. J. — Belfrey, Kentucky
Staker, N. W. — Delbarton

Monongalia

Kerr, Lorin E. — Morgantown
Markley, Joseph — Morgantown

Ohio

Clark, George R. — Wheeling
Duffy, Raymond J. — Wheeling
Leibold, Robert W. — Wheeling
Phillips, Howard T., Jr. — Wheeling
Strauch, Robert O. — Wheeling
Wiestling, Helen M. — Wheeling
Young, John Paul, Jr. — Wheeling

Parkersburg Academy

Burley, Lee — Sistersville

Roleigh

Berry, E. Lowell — Montcoal
Fordham, G. F. — Rainelle
Lilly, F. Vivan — Rainelle
Meaney, Richard V. — Beckley
Moore, Michael J. — Beckley

Summers

Stokes, J. W. — Hinton
White, Enoch W. — Hinton

Wyoming

Hiscoe, D. Bonta — Coal Mountain
Sproles, John H. — Mullens

COPIES OF JULY ISSUE NEEDED

The unusually heavy demand for copies of the Convention Number (July, 1950) of the West Virginia Medical Journal has exhausted the supply always retained for future reference in the files at the headquarters offices of the West Virginia State Medical Association.

This is an appeal for copies of the July issue. It is hoped that members of the State Medical Association who do not retain the Journal after it is read will respond to this appeal by sending such copies to the headquarters offices in Charleston.

MRS. W. E. HOFFMAN NAMED SECOND VICE PRESIDENT OF AMA AUXILIARY

Mrs. W. E. Hoffman, of Charleston, third vice president of the Woman's Auxiliary to the American Medical Association, was elevated to the second vice presidency at the annual meeting held in San Francisco, June 27-30. Mrs. Hoffman was elected second vice president at the annual meeting in Atlantic City, 1949. She is immediate past president of the Woman's Auxiliary to the West Virginia State Medical Association.

Mrs. W. E. Hoffman

It is the duty of each of the four vice presidents of the National Auxiliary to develop and supervise the extension program in the region in which she resides. The Eastern Region, which will be represented by Mrs. Hoffman, includes the states of Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Delaware, Maryland, Virginia, West Virginia and the District of Columbia. The total auxiliary membership in the district is 15,152.

Besides Mrs. Hoffman, the following members of the West Virginia Auxiliary were among those present at the San Francisco meeting: Mrs. Ross P. Daniel, of Beckley, president-elect of the State Auxiliary; Mrs. Wade H. St. Clair, of Bluefield; Mrs. James R. Bloss, of Huntington; Mrs. Frank J. Holroyd, of Princeton; and Mrs. George F. Evans, Mrs. Richard K. Hanifan, and Mrs. Charles M. Slater, of Clarksburg.

MLB TO MEET OCT. 2-4

The fall meeting of the Medical Licensing Board will be held at the Capitol, in Charleston, October 2-4, 1950, for the purpose of examining applicants for licensure to practice in West Virginia.

RELOCATIONS

Dr. John B. Harley and his wife, Dr. M. Dorcas Clark Harley, have located for general practice at Terra Alta. They were formerly located at Galloway.

Doctor Harley served for two years in the Medical Corps of the Army, being released in October, 1949, with the rank of Captain. Dr. M. Dorcas Clark Harley was located at Morgantown while her husband was serving with the armed forces.

* * * *

Dr. L. E. Dunman, formerly of Gary, but who has recently been located at St. Francis Hospital in Pittsburgh, has located for practice at Pearisburg, Virginia.

* * * *

Dr. William D. McClung, of Richwood, has located in that city for the practice of general surgery. He will be associated with his brother, Dr. James E. McClung, as a member of the staff of McClung Hospital.

Doctor McClung has just completed a one-year residency in surgery at the Lahey Clinic, in Boston. Previously he served a three-year residency in surgery at Mercy Hospital, in Baltimore.

* * * *

Dr. George R. Rosenbaum, formerly of Mullens, and Dr. William C. Cooke, Jr., of Charleston, have located in the latter city, where they will engage in the practice of their specialty of surgery. They have offices in the Noyes Building, at the corner of Quarrier and Broad Streets.

Dr. Rosenbaum served over five years in the Medical Corps of the Army, being released with the rank of Captain, and Doctor Cooke for over two years in that branch of the service, also being released with the rank of Captain. Both Doctor Rosenbaum and Doctor Cook have just completed a four-year residency in surgery at the McGuire Clinic (St. Luke's Hospital), Richmond, Virginia.

* * * *

Dr. B. B. Richmond, of Huntington, has located at Beckley, where he will continue the practice of his specialty of urology. For the past year he has been serving a urological preceptorship under Dr. Ray M. Bobbitt, of Huntington.

* * * *

Dr. Ernest E. McClellan, of Williamson, has moved to Huntington, where he will continue in general practice. He has offices at 1220 Fifth Avenue.

* * * *

Dr. Paul L. Conrad, of Welch, has moved to Gary, where he will continue in industrial practice.

CGH PLANS HOMECOMING DINNER

A homecoming-dinner-dance at the Daniel Boone Hotel in Charleston, September 30, is being sponsored by the alumni of the Charleston General Hospital. The dinner is scheduled for 6:30 P. M., and dancing will continue until 1:00 o'clock.

An invitation is being extended to all members of the alumni and to doctors who have in any way been associated with Charleston General Hospital. Reservations for the subscription affair should be filed on or before September 15 with Mrs. Marilyn Casebolt, Charleston General Hospital. Check for tickets at $4.00 per person should accompany the reservations.

DR. JOHN W. CLINE NAMED AMA PRESIDENT ELECT AT SAN FRANCISCO

Dr. John W. Cline, of San Francisco, was named president-elect of the American Medical Association at the annual meeting in San Francisco, June 27-30. He will be installed at the annual meeting in Atlantic City in June, 1951.

Doctor Cline is a native of Santa Rosa. He received his A. B. degree at the University of California in 1921; M. D., Harvard. He is a surgeon, and has served as assistant clinical professor of surgery at Stanford Medical School. He is a past president of the San Francisco County Medical Society and the California Medical Association. He has been a member of the AMA House of Delegates since 1945.

Dr. Rufus B. Robins, of Camden, Arkansas, was named vice president. He is now serving as speaker of the House of Delegates of the American Academy of General Practice. Dr. Leonard Larson, of Bismarck, North Dakota, and Dr. Thomas P. Murdock, of Meriden, Connecticut, were elected members of the Board of Trustees.

Dr. George F. Lull was reelected, and Dr. F. F. Borzell, of Philadelphia, continues as speaker of the House.

The overall registration was 23,655, which figure includes 10,119 fellows and members of the American Medical Association. It was the largest attendance of any AMA session ever held in San Francisco.

The registration shows that 19 West Virginia doctors attended the meeting.

The 1950 clinical or interim session of the American Medical Association has been moved from Denver to Cleveland on account of delay in the construction of the Denver auditorium where scientific meetings and exhibits were to have been held. The Cleveland meeting is scheduled for December 5-8.

ANNUAL ICS MEETING AT CLEVELAND

The fifteenth Annual Assembly and Convocation of the United States Chapter of the International College of Surgeons will be held at Cleveland, Ohio, October 31-November 1-3, 1950.

Dr. George M. Curtis, of Columbus, who is appearing as a guest speaker at the 83rd annual meeting of the West Virginia State Medical Association at White Sulphur Springs, is chairman of the Assembly.

The program will include scientific sessions on subjects in the fields of general surgery; eye, ear, nose and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic and neurological surgery. In addition, an extensive technical and scientific exhibit will be presented by leading manufacturers of surgical instruments, x-ray apparatus, operating room and hospital equipment, pharmaceuticals and others.

Doctors of medicine interested in surgery and its advancement are invited to attend. A copy of the program may be obtained by writing to Arnold S. Jackson, M. D., Secretary, Jackson Clinic, Madison 4, Wisconsin. Hotel reservations may be made with the Committee on Hotels, International College of Surgeons, U. S. Chapter, 511 Terminal Building, Cleveland 13, Ohio.

AIR POLLUTION STUDY IN HANCOCK

The state department of public health does not have a division or bureau devoted to problems of air pollution control, but the bureau of industrial hygiene, in addition to its regular duties, has been devoting much time to the problem.

Many requests for technical assistance have had to be declined because of limited personnel and lack of equipment and funds, but the bureau has insofar as possible served in an advisory capacity to committees set up in various communities.

The bureau has now agreed to provide technical advice to the Hancock County health department, which is working with a local committee organized in an effort to obtain control measures for that area.

The state department of health attributes the air pollution problem in West Virginia to the state's deep narrow valleys and low wind velocities. Studies of air pollution have already been made in Kanawha, Hancock, Brooke, and Monongalia counties.

MEDICAL OFFICER POSITIONS

Medical Officer positions in the Federal Service paying $5400, $6400. and $7600 per year will be filled from an examination recently announced by the Director, Eighth U. S. Civil Service Region, St. Paul, Minnesota. Positions paying the above cited salaries are now vacant and there is an immediate need to fill these positions.

Medical doctors who have just completed their internship are eligible for the positions paying $5400. Medical doctors with one or two years' experience performing responsible medical doctor duties are eligible for the positions paying $6400 and $7600 per year, respectively. Applications for these positions will be accepted until further notice.

Application forms may be obtained at any first- or second-class post office. A copy of the examination announcement may be obtained by writing the Director, Eighth U. S. Civil Service Region, St. Paul Post Office and Customhouse Building, St. Paul 1, Minnesota.

DR. GAGE AGAIN HEADS S. E. SURGICAL GROUP

Dr. E. L. Gage, of Bluefield, was re-elected chairman of the West Virginia Section, Southeastern Surgical Congress, at the annual meeting held at White Sulphur Springs, July 13-15, 1950, in conjunction with Sections of the Congress from Virginia, Maryland, and the District of Columbia.

Dr. Francis L. Coffey, of Huntington, was elected vice chairman, and reelected treasurer. Mr. R. J. Wilkinson, Jr., of Huntington, was reelected secretary.

Doctor Gage will serve as a member of the Council of the Southeastern Surgical Congress for a term of four years.

Another meeting of Sections of the Southeastern Surgical Congress from Virginia, Maryland, West Virginia, and the District of Columbia, will be held in 1951 in some city in Maryland to be designated by the Council.

SCIENTIFIC EXHIBITS AT SOUTHERN MEDICAL

A general invitation has been extended by Southern Medical Association to doctors to sponsor and set up scientific exhibits in connection with the 44th annual meeting, at St. Louis, November 14-16, 1950.

Exhibits will be shown by individual doctors and not by institutions, and the only exception to the rule will be exhibits by local, state, and federal health departments and state and national medical institutions.

According to Mr. C. P. Lorenz, secretary-manager, all scientific exhibits will be arranged by subjects. As usual, there will be three awards, and the Committee in charge is authorized to award honorable mention to exhibits not chosen for first, second, or third place. The awards will go only to exhibits from within the states from which the Southern Medical Association draws its members.

There is no charge for the exhibit booth, the signs, or the lighting, and the amount of space will be determined by the exhibitor's needs.

Applications for space must be filed by September 15, and all inquiries should be addressed to Southern Medical Association, Empire Building, Birmingham, Alabama.

DOCTOR DYER HEADS CDP DIVISION

Dr. N. H. Dyer, state director of health, has been appointed by Governor Okey L. Patteson and Adjutant General Charles R. Fox as chief of the Medical and Health Division of the State Civil Defense Program.

The division will be in charge of all programs arranged for the care of the sick and wounded, and will determine measures to be taken to safeguard civilians against atomic, biological and chemical warfare. It will also be charged with the maintenance of sanitary services, provision of medical supplies, organization of emergency hospitals, and mobilization of health personnel.

Those in charge of the civil defense program feel that possible attacks on our civilian population can be effectively overcome through the proper mobilization of health manpower and facilities.

PG COURSE IN GENERAL MEDICINE

A continuation course for physicians on the subject of "Practical Problems in General Medicine" will be presented September 21-23 by the Frank E. Bunts Institute and the Cleveland Clinic, at Cleveland.

Dr. M. A. Blankenhorn will be the speaker on the opening evening and will present a paper on "The Rickettsial Diseases." Doctor D. W. Pickering, director of the Medical Unit, St. Mary's Hospital, London, England, and Dr. E. Braun-Menendez, of Buenos Aires, Argentina, will present papers on the "Pathogenic Basis of the Treatment of Hypertension."

Copies of the program and complete information concerning the continuation course may be obtained from the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6, Ohio.

AMA PUBLICITY CAMPAIGN MOVES INTO HIGH GEAR EARLY IN OCTOBER

A publicity campaign that will include paid advertisements which will appear during the week of October 8, 1950, in every bona fide daily and weekly newspaper in the United States, has been approved by the Board of Trustees and the Campaign Coordinating Committee of the American Medical Association. The program outlined will also include paid advertisements in more than 30 leading national magazines and many advertising trade publications.

The radio advertising program, which will be broadcast over 300 radio stations during the week of October 8, will consist of intensive "spot" announcements.

The entire program will be under the personal supervision of Clem Whitaker and Leone Baxter, who are directing the National Education Campaign of the American Medical Association.

According to Whitaker & Baxter, the advertising program will not be institutional in character. The principal objective is to increase the availability of good medical care to the American people through the medium of voluntary health insurance. The advertising copy will be designed to make the American people health insurance conscious, and to encourage the extension and development of prepaid medical and hospital service plans as a means of "taking the economic shock out of illness."

Another objective is to alert the American people to the danger of socialized medicine and to the threatening trend toward "State Socialism" in this country.

DR. BELKNAP NAMED PEDIATRIC CONSULTANT

Dr. Helen Belknap, of South Charleston, has been appointed pediatric consultant to the division of maternal and child hygiene to the department of health. She has been serving for the past three years as part-time consultant, and at the same time continuing the practice of her specialty of pediatrics. She succeeds Dr. Hallie Isabel Morgan. The appointment was made by Dr. N. H. Dyer, state director of health.

Doctor Belknap is a native of Gassaway. She received her A. B. and B. S. from West Virginia University, and her M. D. degree from Rush Medical College, in 1941. She completed her internship at Oak Park Hospital, Oak Park, Illinois, and served a two-year residency in pediatrics at Cook County Hospital, Chicago. She was licensed to practice in West Virginia in 1945, and located at St. Albans. She opened offices in South Charleston in November, 1948.

NEW TB ASSOCIATION IN MINGO

Dr. E. T. Drake, of Williamson, has been elected president of the Mingo County Tuberculosis and Health Association, which was organized at a meeting in Williamson, June 19. Mrs. Muriel Bradley will serve as executive secretary for the new organization.

Dr. Henry C. Huntley, director of disease control, and Mr. Albert Rhudy, director of the bureau of tuberculosis control of the state health department, were guest speakers at the meeting.

UNAUTHORIZED PRACTICE BY HOSPITALS DEFINED BY STATE ATTORNEY GENERAL

In an opinion handed down on July 11, 1950, William C. Marland, attorney general of West Virginia, held that a hospital which employs a physician on a salary basis and includes services performed by him as an item of expense on statements rendered the hospital patients, is engaged in the unauthorized practice of medicine "within the meaning of that term as defined by law in this state."

The opinion was written by Thomas J. Gillooly, assistant attorney general. The question of the employment of physicians by hospitals on a salary basis and the subsequent submission of bills to patients including services rendered by such physicians had been referred to the attorney general for an opinion by Dr. N. H. Dyer, state director of health. Doctor Dyer is in charge of the new hospital licensing law passed by the legislature in 1949.

The opinion rendered by the attorney general is incorporated in a letter dated July 11, 1950, addressed to Doctor Dyer. The letter follows:

STATE OF WEST VIRGINIA
OFFICE OF THE ATTORNEY GENERAL
CHARLESTON 5

July 11, 1950

N. H. Dyer, M. D.
State Director of Health
Charleston 5, West Virginia

Dear Doctor Dyer:

This will acknowledge receipt of your letter in which you request our opinion as to whether certain hospitals in West Virginia are now practicing medicine in contravention of our statutes. The facts as outlined in your letter are as follows:

> "Each hospital patient is charged a per diem rate. Included in such rate are the costs for certain medical services rendered to the individual while such person is a patient at the institution. These medical services include treatment by a licensed physician. The cost for all of the services so rendered the patient is made a part of the hospital statement and paid as one bill. This mentioned policy of per diem rates has grown to the point where many hospitals employ licensed physicians on a salary basis. This, of course, means that the hospital collects the entire bill from the patient, and remits to the physician not the remuneration due for services rendered but that salary due as an employee."

The principal question seems to resolve itself to this: Whether a hospital in West Virginia may practice medicine through the services of a licensed physician.

Code, 30-3-1, is as follows:

> "Any person practicing or offering to practice medicine and surgery in this State shall be required to submit evidence that he is qualified so to practice, and shall be licensed as hereinafter provided."

Code, 30-3-2, is as follows:

> "The term 'practice medicine and surgery', as used in this article, shall be construed to mean the treatment of any human ailment or infirmity by any method. To open an office for such purpose or to announce to the public in any way a readiness to treat the sick or afflicted shall be deemed to engage in the practice of medicine and surgery within the meaning of this article: Provided, however, that the provisions of this article, with the exceptions of sections eight and ten, shall not apply to dentitsts, dental hygienists, nurses, optometrists, chiropodists, osteopathic physicians and surgeons, midwives, or chiropractors, regularly licensed or registered as such under the provisions of this chapter applicable to such professions and occupations, in the practice of their respective professions and occupations; nor to physicians or surgeons living in other states and duly qualified to practice medicine therein who shall be called in consultation into this State by a physician or surgeon legally entitled to practice medicine and surgery in this State; nor to commissioned officers of the United States army, navy or marine hospital service when in the actual discharge of their duties as such; nor to the practice of the religious tenets of any church in the administration to the sick or suffering by mental or spiritual means whether gratuitously or for compensation: Provided, that sanitary and public health laws shall be complied with: And provided further, that no practices shall be used which may be dangerous or detrimental to life or health and that no person shall be denied the benefits of accepted medical and surgical practices."

Chapter 16, Article 5B, provides for the regulation and licensing of hospitals and similar institutions. Section 1 thereof provides, in part, as follows:

> "Hospital, sanatorium, rest home, nursing home, and other related institutions within the meaning of this article, shall mean any institution, place, building, or agency in which an accommodation of five or more beds is maintained, furnished or offered for the hospitalization of the sick or injured or care of any person requiring or receiving chronic or convalescent care. Nothing contained in this article, however, shall apply to hotels or other similar places that furnish to their guests only board and room, or either of them.
>
> "*Nothing in this article shall authorize any person, partnership, association, corporation, or any local governmental unit or any division, department, board or agency thereof to engage in any manner in the practice of medicine, as defined by law.* This article shall not be construed to restrict or modify any statute pertaining to the placement or adoption of children." (italics ours.)

Most of the questions involved here have been dealt with in some respect by the courts. These cases usually involve the right of a corporation to practice medicine. If there be hospitals which are organized in another manner, the principals of law discussed below would be equally applicable to them as to corporations.

It is the general rule that a corporation cannot practice a learned profession. 19 C.J.S., Corporations, Section 956(a). It is said that a corporation cannot qualify to practice a profession since it can have neither honesty nor conscience and its loyalty must be rendered to its managing officers, directors and stockholders. *Dr. Allison, Dentist, Inc.* v. *Allison,* 196 N.E. 799, 360 Ill. 638.

It is also the majority rule that a corporation may not employ qualified practitioners to carry on the busi-

ness of practicing for it. 19 C.J.S., Corporations, Section 956 (b).

In the leading case of *People by Kerner* v. *United Medical Service*, 362 Ill. 442, 200 N.E. 157, it is stated:

> "The respondent corporation earnestly contends that the ownership of a clinic, with offices where the treatment of disease is engaged in solely by licensed and registered physicians and surgeons who are employed by the corporation which receives the fee charged the patients does not constitute the practice of medicine by the corporation. The respondent argues that the fact that the contract of payment for the medical services to be rendered is made between the corporation and the patient does not change the professional relationship between the patient and the various licensed and registered practitioners who treat him in the corporation's office. To support its contention, the respondent places reliance upon State v. Brown, 37 Wash. 97, 79 P. 635, 636, 68 L.R.A. 889, 107 Am. St. Rep. 798, in which the statute attacked required an examination and license in order to 'own, . . . run or manage' a dental office. The decision that this statute was void, and also the decisions in State Electro-Medical Institute v. Platner, 74 Neb. 23, 103 N.W. 1079, 121 Am. St. Rep.706, and State Electro-Medical Institute v. State, 74 Neb. 40, 103 N.W. 1078, 12 Ann. Cas. 673, cited by the respondent, are contrary not only to the views of this court expressed in Winberry v. Hallihan, 361 Ill. 121, 197 N.E. 552, Dr. Allison, Dentist, v. Allison, 360 Ill. 638, 196 N.E. 799, 800, and People v. People's Stock Yards State Bank, 344 Ill. 462, 176 N.E. 901, but also to the weight of authority. People v. John H. Woodbury Dermatological Institute, 192 N.Y. 454, 85 N.E. 697; State v. Bailey Dental Co., 211 Iowa, 781, 234 N.W. 260; People v. Painless Parker Dentist, 85 Colo. 304, 275 P. 928; Painless Parker v. Board of Dental Examiners, 216 Cal. 285, 14 P. (2d) 67. * * *"

According to the annotations in 103 A.L.R. at page 1240, the majority, though not all, of the decisions on the subject hold that neither a corporation nor any other unlicensed person or entity may engage in the practice of medicine, surgery or dentistry, through licensed employees. See also the case of *People* v. *United Medical Service* to the same general effect, and quoting *Allison* v. *Allison, supra*, that, "to practice a profession requires something more than the financial ability to hire competent persons to do the actual work. It can be done only by a duly qualified human being, and to qualify, something more than mere knowledge or skill is essential. * * * No corporation can qualify."

In the case of *Stuart Circle Hospital Corp.* v. *Curry* (Va.), 3 S.E. 2d 153, it was held that while a hospital may not be licensed to practice medicine, within the intent of the broad statutory definition thereof, it may actually engage in so much of said practice as is customary and necessary in the proper conduct of its business, without being required to comply with the regulations provided for an individual. However this exception was based on a statutory exemption of hospitals from the prohibition that no one except a licensed physician may practice medicine. It is significant that no such exemption exists under West Virginia statutes. Similarly, in New York it has been held that the general rule that a corporation may not practice medicine has its exception in charitable hospital organizations, organized for that express purpose. However, private proprietary hospitals come within the general rule. *Goldwater* v. *Citizens Casualty* Co., 7 N.Y. Sup. 2d 242; *People* v. *John H. Woodbury Dermatological Institute*, 192 N.Y. 454, 85 N.E. 697. In the latter case the Court held that "hospitals, dispensaries, and similar corporate institutions which are unquestionably authorized by law to practice medicine, although, of course, only through the agency of natural persons who are duly registered as physicians" do not violate the law by practicing medicine. Once again, however, the exception to the rule is based on express statutory provisions. In the case of *United States* v. *American Medical Association*, 110 Fed. Rep. 2d 703, the Court stated:

> "* * * And so it has been held under varying conditions, speaking generally, that where a corporation operates a clinic or hospital, employs licensed physicians and surgeons to treat patients, and itself receives the fee, the corporation is unlawfully engaged in the practice of medicine. This is true because it has been universally held that a corporation as such lacks the qualifications necessary for a license, and without a license, its activities become illegal. It has also been said that the relationship of doctor and patient, well recognized in the law, would be destroyed by such an arrangement. On the other hand, some courts have drawn a distinction between practicing medicine and merely furnishing medical services."

This question has never been decided in this state. However our court in the case of *Eisensmith* v. *Optical Company*, 115 W. Va. 776, 178 S.E. 695, held that a corporation was forbidden by Article 8, Chapter 30, Code 1931, from practicing optometry. The corporation in question employed registered optometrists to perform the actual work. The optometrists were subject to dismissal by the corporation and were paid a weekly salary by it in addition to a small commission on excess receipts. They also agreed with the optical company that they would not practice optometry in the trade area in which they were located within three years from the termination of employment with the corporation. Judge Maxwell, in his concurring opinion, made the following significant statement:

> "All of our statutory provisions in respect of professions and occupations are grouped in Chapter 30 of the Code. In the articles regarding pharmacists, embalmers and engineers, special provision is made for the conducting of such occupations or professions by corporations employing persons licensed under the statute to perform the particular services involved. *It would seem that if it had been the legislative intent to authorize corporations to practice optometry through the employment of licensed optometrists, it would have followed the plan employed as to the three professions or occupations enumerated and have made a clear and specific provision therefor.*" (italics ours.)

With regard to the practice of medicine by hospitals through the employment of licensed physicians, there is not only an absence of any clear and specific provision therefor in Code, 30-3, but rather, legislative intent may be gleaned from Code, 16-5B-1, quoted

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above, which deals with hospitals, and which specifically provides that nothing within this article shall authorize any of the enumerated legal entities to engage in any manner in the practice of medicine as defined by law.

It is therefore our opinion that a hospital which employs a licensed physician on a salary and includes medical services performed by him as an item of expense on bills to its patients, and necessarily controls his discretion even if only in a general way as to the patients he shall treat and the method of treatment, is engaged in the unauthorized practice of medicine within the meaning of that term as defined by law in this state.

Very truly yours,

WILLIAM C. MARLAND,
Attorney General.

TJG/jh By THOMAS J. GILLOOLY, Assistant.

MLB SUSPENDS LICENSE

The license of Dr. F. Edgerton Evans, of Charleston, was suspended by the Medical Licensing Board at a meeting held at Charleston, July 10. The suspension will be effective August 1, 1950, and will continue pending an appeal to the supreme court by Doctor Evans from a Kanawha county court verdict of guilty to a charge of performing an illegal operation.

According to Dr. N. H. Dyer, secretary of the Medical Licensing Board, the effective date of the suspension of Doctor Evans' license was fixed as August 1 to enable him to arrange for medical care of his patients now under treatment.

COUNCIL RENEWS VA CONTRACT

The contract with the Veterans Administration for home town care of veterans in West Virginia has been renewed by the Council and the Veterans Administration for the term expiring June 30, 1951. The contract was renewed without change except for the addition of the following paragraph:

16. Except as otherwise specifically provided in this contract, all disputes concerning question of fact arising under this contract shall be decided by the contracting officer, subject to written appeal by the contractor within thirty (30) days to the head of the department concerned or his duly authorized representatives, whose decision shall be final and conclusive upon the parties thereto.

The number of members of the West Virginia State Medical Association participating in the program totaled 1,046 as of July 1, 1950.

DR. KARL MYERS IN ENGLAND

Dr. Karl Myers, of Philippi, president of the Barbour-Randolph-Tucker Medical Society, is in London, England, where is attending sessions of the International Congress of Radiology.

DOCTOR LAHEY AMGA PRESIDENT ELECT

Dr. Frank H. Lahey, of Boston, who appears as a guest speaker on the program for the final general session held in connection with the 83rd annual meeting of the West Virginia State Medical Association, was named president elect of the American Medical Golfer's Association at the annual meeting in San Francisco, late in June.

ACTING HEAD FOR HUNTINGTON HOSPITAL

Dr. W. R. VanDenBosch, of Huntington, has been named acting superintendent of the Huntington State Hospital to succeed Dr. Edward F. Reaser, who died unexpectedly July 18. Announcement of the appointment was made late in July by Joe F. Burdett, president of the board of control.

Doctor VanDenBosch has been serving as assistant to Doctor Reaser. A native of Bradenton, Florida, he received his M. D. degree from Indiana University School of Medicine.

He served an internship at the U. S. Naval Hospital at Oceanside, California, and was released from the Medical Corps of the Navy in 1945.

WHEELING WILL FLUORIDATE CITY WATER

Wheeling will be the first West Virginia city to fluoridate its water supply for the purpose of protecting and endeavoring to retard tooth decay among the children in that area.

The sum of $1,500 was appropriated by the city council for the purpose for the fiscal year ending June 30, 1951. It is estimated that this added protection to the teeth of the young people will cost an average of but two and one-half cents per person.

Favorable action was taken by the council upon the recommendation of Dr. A. C. Plant, Wheeling dentist, and Mr. A. R. Todd, superintendent of the city filtration plant.

NEW HEAD FOR MENTAL HYGIENE COMMITTEE

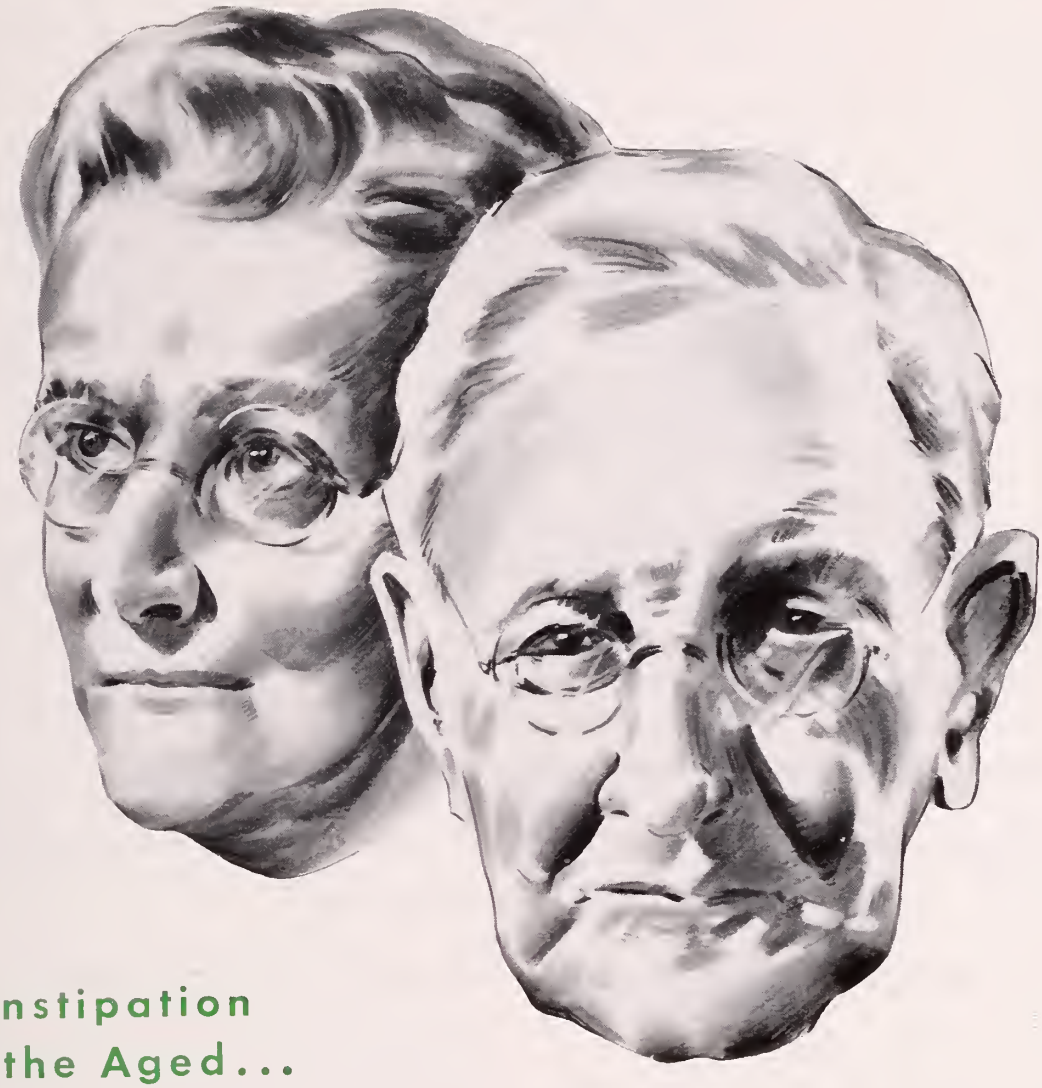
Dr. William B. Rossman, Charleston psychiatrist and neurologist, has been named chairman of the committee on mental hygiene to succeed Dr. Edward F. Reaser, of Huntington, who died July 18. The appointment was made by Dr. Charles E. Watkins, President of the West Virginia State Medical Association.

DOCTORS—STIII 5,000 A YEAR

It is not generally realized how the load of patients upon the private physician has increased, especially in rural areas. Forty years ago the medical schools of the country were turning out about 5,000 doctors a year. In that same forty years, the population of the United States has increased by two-thirds. Today the medical schools are still turning out about 5,000 doctors a year. With this lag in the number of trained physicians, there is no escaping the conclusion that the demands upon the family doctor's time have increased tremendously.—Charlotte Donlon, M. D., in J. Am. Med. Women's Assn.

HOSPITAL HEADACHES

Patient: I can't eat this soup.
Orderly: Sorry, I'll get the nurse.
Patient: Nurse, I can't eat this soup.
Nurse: Sorry, I'll get the dietitian.
Dietitian: What's wrong with it?
Patient: Nothing. I haven't any spoon.—R. N.



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Brooke	H. L. Hegner	Wellsburg	W. T. Booher	Wellsburg	
Cabell	Francis L. Coffey	Huntington	James A. Heckman	Huntington	2nd Thurs.
Centrol West Virginia	G. D. Hill	Camden-on-Gauley	Theresa O. Snaith	Weston	Quarterly
Doddridge	R. S. White	West Union	A. Poole	West Union	
Eostern Ponhandle	Curtis G. Power	Mortinsburg	G. O. Martin	Martinsburg	Quarterly
Fayette	E. V. Nutter	Gauley Bridge	DeWitt Peck	Montgomery	2nd Tues.
Greenbrier Volley	James P. Baker	White Sul. Spgs.	George Lemon	Lewisburg	2nd Wed.
Hancock	Leonard Yurko	Weirton	R. E. Flood	Hollidays Cove	2nd Tues.
Harrison	John F. McCuskey	Clarksburg	L. D. Zinn	Clarksburg	1st Thurs.
Kanawha	T. Maxfield Barber	Charleston	Robert C. Bock	Charleston	2nd Tues.
Logan	W. E. Brewer	Logan	C. H. Hagan, Jr.	Holden	2nd Wed.
Marion	L. Rush Lambert	Fairmont	Geo. T. Evans	Fairmont	Last Tues.
Marsholl	Don S. Benson	Moundsville	David L. Ealy	Moundsville	Semi-Ann.
Mason	(Vacancy)		C. Leonard Brown	Pt. Pleasant	
McDowell	A. B. Corr	Wor	Otis E. Linkous, Jr.	Welch	2nd Wed.
Mercer	Hampton St. Clair	Bluefield	Frank J. Holroyd	Princeton	3rd Thurs.
Mingo	J. Carl Lawson	Williamson	E. T. Drake	Williamson	2nd Thurs.
Monongalia	Lucien M. Strawhn	Morgantown	Maynard Pride	Morgantown	1st Tues.
Ohio	W. Carroll Boggs	Wheeling	R. Alan Fawcett	Wheeling	4th Tues.
Parkersburg Academy	Paul L. McCuskey	Parkersburg	S. W. Goff	Parkersburg	1st Wed.
Potomac Volley	T. T. Huffmon	Keyser	Harry Coffman	Keyser	1st Thurs.
Preston	Harold H. Cashman	Hopemont	C. Y. Moser	Kingwood	1st Thurs.
Raleigh	C. A. Smith	Raleigh	P. E. Vaughan	Beckley	3rd Tues.
Summers	W. L. Van Sont	Hinton	D. W. Ritter	Hinton	
Taylor	R. D. Stout	Grafton	Poul P. Warden	Grofton	Last Thurs.
Wetzel	T. B. Gordon	New Martinsville	O. T. Coffield	New Martinsville	Monthly
Wyoming	R. C. Hatfield	Oceana	J F. Biggart	Mullens	

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John F. Morris, Huntington, President; Newman H. Newhouse, Charleston, Vice President; and Arkie B. Bowyer, Charleston, Secretary-Treasurer.

Scientific Assembly, W. Va. Heart Association

John E. Stone, Huntington, President; Lawrence B. Gang, Huntington, Vice President; Wade H. Rardin, Beckley, Treasurer, and Fred Richmond, Beckley, Secretary.

West Virginia Ob. and Gyn. Society

Charles L. Goodhand, Parkersburg, President; A. Morgan Dearmon, Parkersburg, Vice President; and Clarence H. Boso, Huntington, Secretary-Treasurer.

Association of Pathologists of W. Va.

Marshall W. Sinclair, Bluefield, President; and Melford L. Hobbs, Morgantown, Secretary-Treasurer.

ANNUAL REPORTS

DIABETES COMMITTEE

An important meeting of the Diabetes Committee was held early in January, 1950, when the projects for the new year were considered.

At the request of the committee which served during 1949, Dr. Charles E. Watkins appointed three additional members, i. e., Dr. O. H. Brundage and Dr. John H. Gile, of Parkersburg, and Dr. M. L. Hobbs, of Morgantown. The committee felt that the projects to be sponsored in 1950 would be important and would require additional work, and, therefore, the membership of the committee should be enlarged.

Your Committee is undertaking the following projects for 1950:

The formation of a West Virginia Diabetes Association. For this work there has been frequent contact with the American Diabetes Association for suggestions and help. The plan is to establish the Clinical Society of the State Diabetes Association during the Annual Meeting of the West Virginia State Medical Association at White Sulphur Springs, July 27-29, 1950.

Taking advantage of the ground work that had been laid by the Diabetes Committee in recent years, the present committee is sponsoring a camp for diabetic children in West Virginia. The camp grounds are being donated and the services of three councillors supplied by Carbide & Carbon Chemicals Corporation, of South Charleston. The site is "Camp Cliffside," on Alum Creek, about twenty miles from Charleston. A resident physician, nurse, dietitian, and technician have volunteered their services without compensation.

The camp period will be for one week during August, 1950. All diabetic children between the ages of 7 and 13 are eligible to attend. There is no charge made for any child, although donations will be accepted from parents financially able to help in this important work. There will be supervised play at camp, but no attempt made at formal instruction in this short period of time.

The committee has attempted to keep the doctors throughout the state informed of its activities, together with such other information regarding diabetes as might be interesting, by monthly articles in the West Virginia Medical Journal. Information concerning the proposed State Diabetes Association, camp for diabetic children, and news and book reviews have been presented. The committee has of necessity worked hard to try to establish the above projects and it is hoped that, as the State Diabetes Association grows, it can take over the function of maintaining the camp

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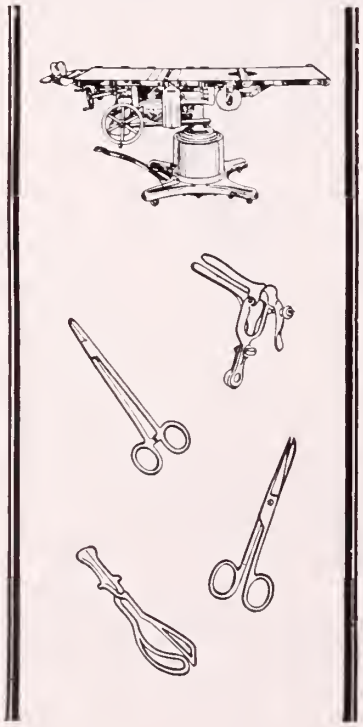

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which the committee hopes will expand to a full six weeks during the next few years.

Respectfully submitted,

George P. Heffner, M. D.,
Chairman
W. A. Thornhill, M. D.
O. D. Ballard, M. D.
F. R. Whittlesey, M. D.
O. H. Brundage, M. D.
John H. Gile, M. D.
M. L. Hobbs, M. D.
W. E. Bundy, M. D.

* * * *

COMMITTEE ON INDUSTRIAL HEALTH

Your Committee on Industrial Health respectfully suggests that the West Virginia State Medical Association approve the following program of the Council on Industrial Health of the American Medical Association for development of local industrial health services:

A. Objectives:

a. Creation of public interest and demand.

b. Clarification of industrial health objectives and their integration into the pattern of community health service.

c. Improve professional training and standards.

d. Better medical organization for industrial health on the part of individual physicians and the medical societies.

B. Program:

a. The expansion of the practice of occupational medicine and surgery and the continued development of industrial health, including industrial hygiene, subject to such changes as may be necessary to maintain and elevate the quality of services and to increase their availability.

b. Advance the principle that sound and properly supervised industrial health programs should be organized in all communities and that the responsibility for implementation rests jointly on management, labor, the medical profession, and official and other recognized organizations concerned with improving the health and working conditions of all wage earners.

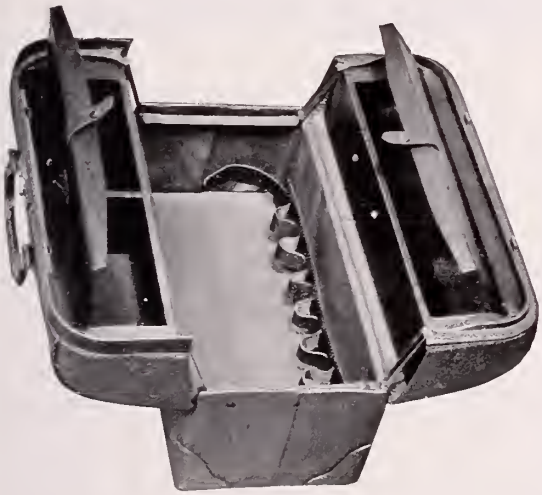
c. The endorsement by medical societies of recognized industrial health plans consistent with the platform of the American Medical Association.

d. The establishment of just and equitable remuneration for professional services rendered to industry.

C. Membership:

Membership of state and county Industrial Health Committes may consist of:

1. Industrial physicians—minimum 2.
2. Private physicians—minimum 2.
3. Local health units—minimum 1.



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4. Physicians interested in medical relations in workmen's compensation—minimum 1.
5. Others in accordance with the desires of the State Medical Association.

This committee should understand the components of adequate service and be prepared to adjust them to existing medical and public health facilities and methods of community practice.

D. Committee Procedure:

a. The committee in the county society should request instructions from the committee on industrial health in the State Medical Association and from the state division of industrial hygiene in order to determine:
   1. The responsibility already existing between government, industry, labor and the medical and dental professions.
   2. The principal industrial health problems of the local community as a basis for remedial action.
   3. The proper organization and employment of local medical and health facilities.
   4. Supplementary services which can be called on from sources outside the community itself.
   5. The needs of small industry and how to establish effective service by part time activity.

b. The names of all physicians now serving or willing to serve in industry (even though only part time) should be determined. These physicians should be invited to attend a meeting at which the results of the above procedures can be reported and general details of the program presented for discussion and adoption.

c. Conferences should be held with other essential professional groups, particularly industrial or public health nurses, industrial hygiene engineers, and dentists in order that dependable arrangements for services provided by these groups may be made.

d. The county medical society committee can then request a conference with the executives or a representative committee of the local manufacturer's association, chamber of commerce, or both, to describe the program and to determine how the medical profession and the local health department can accelerate and improve production through appropriate health activity.

e. Cooperation may be secured from local labor organizations in which health education should emphasize particularly non-occupational factors which are of importance to the health of workers, namely, oral health, nutrition, housing, proper use of leisure time, recreation, and other related activities.

The committee representing the local labor organization should be requested to assume a considerable share of responsibility for the health educational as-

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pects of the program and should not be hesitant in asking the local committee on industrial health for advice and guidance in matters pertaining to health welfare of their workers.

E. Basic Elements in an Industrial Medical Service:

a. A competent physician who takes genuine interest in applying the principles of preventive medicine, surgery and hygiene to employed groups and who is willing to devote regular hours to such service in the working environment.

b. Industrial nurses with proper preparation, acting under the physician's immediate supervision or under standing orders developed by him.

c. Industrial hygiene service directed at improvement of working environment and control of all unhealthful exposures, to be provided by properly qualified consultants and agencies.

d. A health program which should include:

1. Prompt and dependable first aid, emergency and subsequent medical and surgical care of all industrially induced disability in accordance with the statutes governing workmen's compensation.
2. Health conservation of employees through physical supervision and health education.
3. Close correlation with the family physician, dentist, and other community health agencies for early and proper management of non-occupational illness and injury.
4. Good records of all causes of absence from work as a guide to the establishment of preventive measures.

Respectfully submitted,

J. J. Brandabur, M. D.,
Chairman

A. J. Villani, M. D.
DeWitt Peck, M. D.
F. C. Goodall, M. D.
George O. Nelson, M. D.

* * * *

COMMITTEE ON MENTAL HYGIENE

At a meeting of the Committee on Mental Hygiene held at the headquarters offices of the West Virginia State Medical Association, May 28, 1950, the following conclusions were reached:

1. It is essential that the West Virginia Training School be expanded to receive all institutionalized persons in the state falling in the feeble-minded group, thus removing these individuals from the state hospitals so as to enable such hospitals to accept and care for mentally ill patients instead. The Training School should be staffed with a medical superintendent and the necessary psychiatric staff as well as other personnel needed for this type of organization.

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Surgery of Colon & Rectum, One Week, starting September 11.
Esophageal Surgery, One Week, starting October 16.
Breast & Thyroid Surgery, One Week, starting October 2.
Thoracic Surgery, One Week, starting October 9.
Gallbladder Surgery, Ten Hours, starting October 23.
Fractures & Traumatic Surgery, Two Weeks, starting October 9.
Basic Principles in General Surgery, Two Weeks, starting September 11.
GYNECOLOGY—Intensive Course, Two Weeks, starting September 25.
Vaginal Approach to Pelvic Survery, One Week, starting September 18.
OBSTETRICS—Intensive Course, Two Weeks, starting September 11.
MEDICINE—Intensive General Course, Two Weeks, starting October 2.
Gastro-enterology, Two Weeks, starting October 16.
Gastroscopy, Two Weeks, starting September 11 and October 23.
Electrocardiography & Heart Disease, Four Weeks, starting October 2.
DERMATOLOGY—Formal Course, Two Weeks, starting October 16. Informal Clinical Course every two weeks.
UROLOGY—Intensive Course, Two Weeks, starting September 25.
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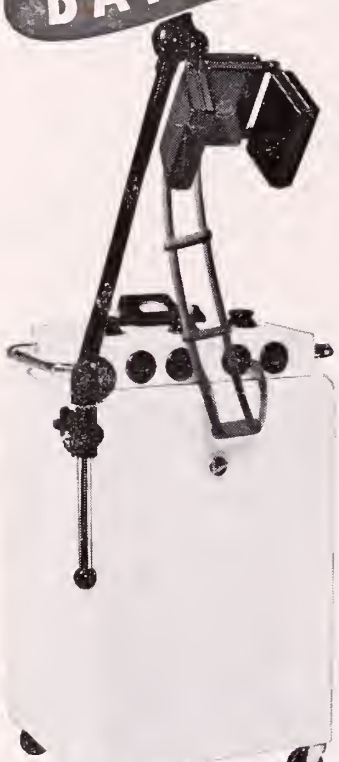

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2. The fact is recognized that there are a large number of emotionally disturbed children in the various communities of the state who cannot be properly handled on an out-patient basis. The committee favors the establishment of a treatment home for such children with the understanding that such a home should be under proper psychiatric supervision and should be equipped with necessary personnel to carry on an active treatment program.

3. It is felt that each of the state hospitals should establish an out-patient clinic program, adding such personnel as may be needed to properly staff such a program. These clinics should be held not only in the hospitals where they would deal with out-patients but should also be held in various communities within the area served by the particular institution for periodical examination and treatment of former patients and all referred patients in such communities.

4. It is felt that it is necessary to arouse more support in the medical profession of the state for the neuro-psychiatric needs in the state. One means of doing this might be to recommend that non-psychiatric physicians be added to this committee.

5. A revision of our present commitment law is badly needed and to accomplish this there should be a joint committee composed of members of the Bar Association and the State Medical Association to make a study of the problems involved, to examine legislation and recommendations from other states, and to prepare a suitable commitment law.

6. It is suggested that the committee communicate with the officials of the component societies, suggesting that one meeting each year be set apart for discussion of neuro-psychiatric problems. The committee will undertake to help such component societies provide speakers if requested to do so.

7. It is suggested that one issue of The West Virginia Medical Journal be devoted to the problems of mental health.

8. The committee feels that a joint meeting with the Board of Control might serve a good purpose with reference to the planning of the Board's program for future expansion of the mental health facilities in the state.

The committee also discussed the organization of a neuro-psychiatric society in the state, with a view to requesting the State Medical Association to create a Section on Nervous and Mental Disorders. It was understood that this matter will be discussed further at the annual meeting at White Sulphur Springs, July 27-29, 1950.

Respectfully submitted,

Edward F. Reaser, M. D.
Chairman
W. B. Rossman, M. D.
O. N. Morrison, M. D.
A. L. Wanner, M. D.
E. L. Gage, M. D.
C. A. Zeller, M. D.

TUBERCULOSIS COMMITTEE

A meeting of the Tuberculosis Committee was held at the headquarters offices of the West Virginia State Medical Association, in Charleston, April 2, 1950, for the purpose of reviewing the work of the year and considering further what recommendations should be made in the annual report to the House of Delegates.

Taking cognizance of the wide variance in the reported death rate in the various counties in 1948, your Committee recommends that physicians be urgently requested to make prompt report of all tuberculosis cases, as well as deaths from this disease. We further recommend that the Bureau of Tuberculosis Control of the State Department of Health make a thorough study of the causes of the wide differences in the reported death rate in tuberculosis, and then recommend what measures should be taken in an effort to assure a lower death rate, especially in the counties where the rate seems to be excessively high.

Diagnostic Service in Each County

We further recommend that each county be urged to adopt a regularly planned diagnostic service, including chest X-ray, to provide proper examination of suspects, contacts, food handlers, janitors, and teachers.

Out-patient Pneumothorax Refills

Your Committee has received reports to the effect that many indigent patients in need of out-patient pneumothorax refills are being discharged from our state sanatoria. Failure to provide this necessary treatment for these patients will undoubtedly result in a physical breakdown for many of them. This is definitely a public health problem and not the responsibility of our tuberculosis institutions. We recommend that sufficient appropriations be sought at the 1951 session of the Legislature to cover the cost of necessary treatment for these patients, and that the expenditure of such funds be supervised by the Bureau of Tuberculosis Control.

Increase in DPA Grants for Families

We feel that we would be somewhat remiss in our responsibilities if we did not mention the great need for an increase in the Department of Public Assistance grants for members of the families of tuberculosis patients. At present, the wife and children of a tuberculosis breadwinner may receive but 50 per cent of the actual amount needed to cover basic minimum needs. This critical situation no doubt accounts for numerous discharges against medical advice, thus predisposing members of such families to tuberculosis. Inasmuch as we are primarily concerned with the tuberculosis group, we recommend that the Legislature be asked to appropriate sufficient funds to raise overall financial assistance for those in need.

Transportation of Tuberculosis Patients

Questions concerning the cost of transporting patients to and from state tuberculosis sanatoria constantly arise. The director of the Department of Public

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Clinical Pathology: E. E. MYERS, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.
MELVIN E. LEA, M. D.

Gynecology and Obstetrics:
EDNA MYERS JEFFREYS, M. D.

Anesthesiology:
C. W. SHAFER, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.

Pediatrics: CORA C. LENOX, M. D.

Anatomic Pathology: S. D. WU, M. D.

Resident Staff:
JOHN E. SUMMERS, M. D., Surgery
HENRY G. STORRS, M. D., Surgery

☆ ☆ ☆

Pharmacist:
S. J. POLLARD, R. P.

Director School of Nursing:
CLIFFORD BURROUGHS, R. N., M. A.

Director of Nursing Service:
MARY R. CHAFFEY, R. N.

Chief Dietitian:
RUTH J. MATTHEWS, B. S. (A. D. A.)

Assistant Director of Clinical Laboratories:
GORDEN S STARKEY, M. S., M. T. (ASCP)

Chief Laboratory Technician:
MALLADOR SHAFFER, B. S., M. T. (ASCP)

Clinical Photographer:
RICHARD CRAWFORD

Chief X-Ray Technician: R. R. RATCLIFFE, R. T.

Business Manager: E. R. DENISON

Administrator:
W. OBED POLING, M. A., M. H. A.

Assistance states that no funds are available for this purpose through that department. Statements covering the transportation costs are submitted to the State Department of Health, but no appropriations have been made for that purpose. The West Virginia Tuberculosis and Health Association is being called upon constantly to meet this need. Undertakers and others bearing the expense of such travel should without question be reimbursed. We recommend that the Legislature, at the regular sessions in 1951, be requested to appropriate sufficient funds to cover these necessary expenses.

Appropriations for State Sanatoria

Your Committee strongly recommends that an effort be made to obtain for regular sanatoria care of tuberculous patients during the biennium ending June 30, 1953, an amount equal to or in excess of present appropriations for that purpose.

Respectfully submitted,

W. P. BITTINGER, M. D., *Chairman*
WILLIAM L. COOKE, M. D.
GEORGE F. EVANS, M. D.
HUGH S. EDWARDS, M. D.
G. R. MAXWELL, M. D.
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OBITUARIES

TYLER ROBERT BOLING, M. D.

Dr. Tyler Robert Boling, 42, of Grantsville, died June 30, 1950, at a hospital in Tuscon, Arizona. Death was due to complications following a long illness incurred while serving with our Armed Forces during World War II.

Doctor Boling was born at Burke's Garden, Virginia, and received his academic education at Roanoke College, and his M. D. degree in 1932 from the Medical College of Virginia. He interned at the United States Marine Hospital at Norfolk, Virginia, and served a residency at Rutherford Sanitarium, in Beckley, 1932-1934. He had served for a year in the United States Public Health Service at San Juan, Puerto Rico.

He located at Grantsville several years ago where, with his brother, Dr. John S. Boling, he established the Boling Clinic.

Doctor Boling served three years with the Army Medical Corps in the South Pacific during World War II, being released in February 1946, with the rank of lieutenant colonel.

Besides his widow, he is survived by two brothers, George, of Burke's Garden, Virginia, and Dr. John S. Boling, of Grantsville.

LORAH O. FOX, M. D.

Dr. Lorah O. Fox, 60, of Ansted, died July 6, 1950, at his home in that city, following a heart attack.

Doctor Fox attended the University of Kentucky, and received his M. D. degree from the University of Maryland School of Medicine, Baltimore, in 1910. He had practiced continuously at Ansted for the past 40 years.

At the time of his death he was president of the Ansted National Bank.

He is survived by his widow, Mrs. Emily V. Fox, two sons, Lorah O. Fox, Jr., of Pearisburg, Virginia, and John G. Fox, of Fayetteville, and his parents, Dr. and Mrs. George Fox, of Ansted.

* * * *

EDWARD FRANKLIN REASER, M. D.

Dr. Edward Franklin Reaser, 53, of Huntington, superintendent of the Huntington State Hospital, died July 18, at a hospital in Huntington. Death was unexpected, although he had suffered a severe heart attack a few months ago. He was at work in his office when stricken.

Doctor Reaser was born at Webster Springs and graduated from the high school in that city in 1914. He received a teacher's certificate from Alderson-Broaddus College in 1915, and his A. B. degree from the Medical College of Virginia in 1930. He served a two-year internship at St. Elizabeth's Hospital, in Washington, D. C., and was licensed to practice in West Virginia in 1933.

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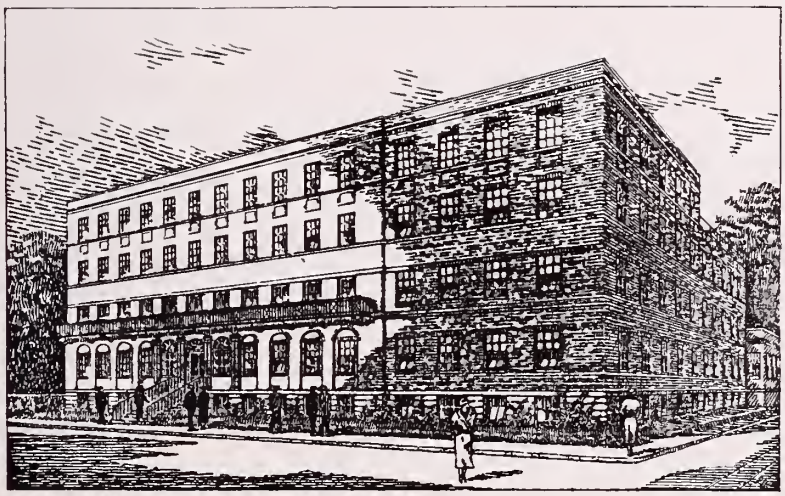

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Doctor Reaser served as assistant superintendent of the Huntington State Hospital, 1933-1946. He resigned to accept appointment as chief psychiatrist of the mental hygiene clinic at the Veterans Hospital in Huntington. He was appointed superintendent of Huntington State Hospital August 1, 1947 to succeed Dr. Charles Trueheart Taylor, resigned.

Doctor Reaser was a member of the Cabell County Medical Society, the West Virginia State Medical Association, and the American Medical Association. He was a diplomate of the American Board of Psychiatry and Neurology, and held membership in the American Psychiatric Association and the Medical Society of St. Elizabeth's Hospital. At the time of his death, he was chairman of the Committee on Mental Hygiene of the West Virginia State Medical Association.

* * * *

IRVIN C. STUMP, M. D.

Dr. Irvin C. Stump, 79, of Clendenin, died July 11, 1950, in a hospital in Charleston following a short illness.

Doctor Stump was born in Roane County, son of the late Dr. and Mrs. Charles E. Stump. He received his M. D. degree from the University of Louisville in 1894 and had practiced in Kanawha County for over 56 years.

He is survived by a son, Irvin C. Stump, Jr., of Louisville; two brothers, Homer, of Clendenin, and Dennis, of Grand Junction, Colorado; and three sisters, Mrs. Lula Simmons, of Spencer, and Mrs. Cora Davies and Mrs. O. W. Engle, of Clendenin.

COUNTY SOCIETIES

MINGO

Judge Charles W. Ferguson, of Wayne, and Dr. Fred B. Quincy, of Williamson, were the guest speakers at a dinner meeting held by the Mingo County Medical Society at the Country Club, at Sprigg, Friday, June 30.

Besides members of the Society, the meeting was attended by several lawyers, dentists, pharmacists and their wives living in the Williamson area. It was the first joint meeting of this nature ever held at Williamson.

Judge Ferguson deplored the crtical shortage of doctors in West Virginia. He said that it is a situation that has existed in this country for a long time, and stressed the fact that the United States has through two World Wars been seriously handicapped by the lack of doctors.

He described the medical, dental, pharmaceutical, and legal professions as "pillars of democracy," and urged that members of all professional groups work together and understand each other.

Doctor Quincy, graduate of the Medical College of Virginia, class of 1900, told of the hardships of a young doctor at the close of the century. He located at Welch upon graduation from medical school and 25 years

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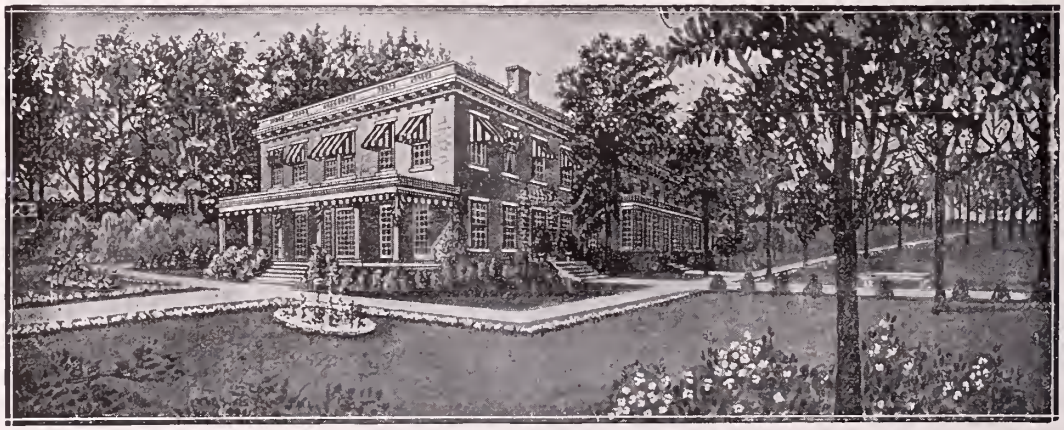

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later moved to Williamson, where he continues to practice.

Doctor Quincy reported that during his 50 years' practice he has delivered 3,199 babies, including one set of triplets and many sets of twins.

He stressed, with Judge Ferguson, the lack of doctors, particularly in the rural areas. He pointed to the high cost of medical education, and emphasized the fact that many doctors decline to locate in rural areas where "men are men and the plumbing is terrible." He supported Judge Ferguson's proposal that something be done to encourage young men to enter the medical field.

Dr. J. C. Lawson, president of Mingo County Medical Society, presided at the meeting, and it was agreed that the affair is to be repeated annually in the future.

The members of the Mingo County Medical Society were entertained at a dinner meeting July 13, 1950, at the home of Dr. W. J. Smith, in Belfry, Kentucky. There was no formal scientific program, but Dr. C. T. O'Boyle was elected to membership at a short business session following the dinner.—E. T. Drake, M. D., Secretary.

WANTED—By well established and older F.A.C.S., a general practitioner for assistant. Married man. Good hospital facilities. Salary first six months, then percentage. Apartment available suburban area, twin cities. Great future. Minnesota License or National Boards.—Box 2R, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia.

BOOK REVIEWS

HANDBOOK OF OBSTETRICS AND DIAGNOSTIC GYNOCOLOGY —By Leo Dayle, M. S., M. D. Pp. 240, with illustrations. First edition. University Medical Publishers, Palo Alto, California. Price $2.00.

The field of obstetrics is well outlined in this handbook, which is, as the author states, neither a textbook, nor a reference book. There is an extensive index, making the book a handy reference for the daily practice of obstetrics. Many line drawings illustrate more complicated conditions and procedures. Tables are included, which would do well in any handbook of medicine or surgery, although, of course, some blood chemistry values may vary with local method of determination.

The section of diagnostic gynecology occupies about one-fiifth of the text. It is brief and the author makes an attempt to present both sides of controversial questions. However, this section is hardly complete, especially, in the fields of reparative surgery and the diagnosis of malignancy, the latter being essentially limited to a two page outline. Nevertheless, this handbook certainly serves a useful purpose.—Henry G. Storrs, M. D.

You can't strengthen the weak by weakening the strong.—Anon.

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Editor
WALTER E. VEST, M. D.
955 Fourth Ave.
Huntington, W. Va.

Managing Editor and
Business Manager
MR. CHARLES LIVELY
Box 1031
Charleston 24, W. Va.

Associate Editors:
EDWARD J. VAN LIERE, M. D.
Morgantown, W. Va.
W. M. SHEPPE, M. D.
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Vol. XLVI SEPTEMBER, 1950 No. 9

WITHOUT FEAR AND TREMBLING*

By CHARLES E. WATKINS, M. D.
Oak Hill, W. Va.

"Chief complaint, present illness, past history" – the old, old, refrain. Trilogy of the case record. Diagnostic trinity. Today the corporate body of the West Virginia State Medical Association once more presents itself for its annual physical examination. Born 83 years ago, its life has been active and varied, its past history distinctly contributory to its feeling of well being – for it has no chief complaint, and it has no present illness.

The driving force and vitality of this Body are witnessed by its activity during the past year: It has continued to fight against socialized medicine, with the opposition being spearheaded by our very active and efficient Public Relations Committee, of which Dr. Frank J. Holroyd, of Princeton, is chairman. West Virginia today stands second in the nation in the number of resolutions adopted by state, district, county and local organizations in opposition to compulsory health insurance.

Officers of the Association, members of the Council and members of the Public Relations Committee have appeared before professional and lay groups in every part of the state to stress the importance of the defeat of socialized medicine. Hundreds of thousands of pieces of printed literature have been distributed, through the Committee, so that their appeal has reached not only the doctor but the patient in his waiting room, the postman who delivers his mail, the janitor of his office building, the office nurse, the medical secretary, the news vendor in the lobby.

The active, nimble mind of the student has been aroused to the point of debate and discussion in the school.

There was support of three of our six Congressmen in the overwhelming defeat of Reorganization Plan No. 27, The fight must and will go on. The dire consequences of defeat are not to be even contemplated.

FOUR-YEAR SCHOOL

While waging battle against the isolated politicalization of medical practice and medical care on the one hand, the Association had also to give its attention to active support of the creation of a four-year school of medicine and dentistry of West Virginia University.

There is no need here to stress the importance of such a school. The overall campus building program of West Virginia University includes the tearing down of the old building to make room for needed improvements. What then?

In the unfortunate controversy over location of the school that followed the first few opening movements, the Council withdrew its recommendation for location of the school at Charleston after objection from the Monongalia County Society, but renewed with fervor its plea to the legislature to establish the school, wherever the location.

Strong support for this project was indicated in the House of Delegates, but apparently the majority of the Senate was little more than lukewarm. Our local medical societies, as well as the dentists, were with us almost to a man; the mem-

*Annual Address of the President, West Virginia State Medical Association, 83rd Annual Meeting, The Greenbrier, White Sulphur Springs, July 28, 1950.

bers of the Board of Public Works were 100 per cent supporting.

ASSOCIATION ACTIVITIES

During the past year the Department of Health of the State of West Virginia has been reorganized under provisions of an Act passed by the 1949 legislature with the support of the State Medical Association and the State Department of Health. We gave wholehearted support to Dr. N. H. Dyer and the public health personnel in their endeavor, and lent all possible aid to the Department in getting the new biennial registration law for doctors under way.

We sponsored through the Public Relations Committee three rural health conferences at Jackson's Mill with the idea of working out some type of rural health program whereby a more prompt and available type of medical care might be offered in the rural areas.

We sponsored a radio-press conference in Charleston which was attended by representatives of over 50 newspapers and journals published in West Virginia. To meet the complaint of the newsmen that the news is old when they receive it, also that they are not allowed to use names, and that the doctor interviewed as a rule refuses to be quoted, it was recommended that a committee be established in each county to be responsible for news published and to see that press and radio are handled in a manner calculated to establish an *entente cordiale* among doctors, citizens and members of the news gathering agencies concerned.

The newsmen felt also that medical ethics probably could stand some revision and modernization with regard to publicity and the newspapers in general. Another complaint voiced by the newsmen, which has been heard again and again from other sources, was the almost universal unavailability of doctors, not only in the rural areas but in cities and towns. Thus it was that in some cities a round-the-clock emergency call system was set up in the hope that this county-wide voluntary plan will make a doctor available at any time of day or night. The Bureau of Physicians and Registered Nurses will be the clearing house for calls.

We have worked unceasingly through our headquarters offices and the various county officers to obtain payment of the AMA assessment for 1949 and the AMA dues for 1950. Contrasted with the payment of the AMA 1949 assessment by approximately 64 per cent of our members, approximately 93 per cent of our active members have paid AMA dues for 1950.

The American Medical Association, with Whitaker and Baxter in charge of the National Education Campaign, will undoubtedly continue to receive full support in the matter of the collection of dues for 1951.

GRIEVANCE COMMITTEE

The Council took a long step forward in its relations with the public by approving the appointment of a state grievance committee which would have full power to investigate matters of an ethical nature referred to it for study from any part of the state including complaints regarding fees and professional services. This work is now handled at the local level by committees of our component societies and by our Councillors. The by-laws have now been amended by the House of Delegates, and a grievance committee has been created, composed of the five living immediate past presidents.

I have not elaborated in particular on all of the various accomplishments of the Association during the past year, but I feel that at this moment there has been sufficient review of the work done by this vital Body to permit us to point with pride to the record of West Virginia medicine during its 1949-50 twelvemonth. We do not 'view with alarm'. We face the future without fear and trembling.

For the new year I propose that the West Virginia State Medical Association continue its active fight for improved medical care for her people. To accomplish this we need:

RECOMMENDATIONS

More doctors! In the United States there is a ratio of doctors to patients of 1 to 700, in West Virginia, 1 to 1400, which means of course that every doctor in West Virginia is responsible for approximately twice as many patients as is the doctor in the United States as a whole. As is the situation in other states, our doctors are located primarily in the cities, leaving some rural areas with a doctor to patient ratio as high as 1 to 2000. And that in the more scattered areas! Along with this must be taken into consideration the poor and, at times, impassable state of the roads, if there is a road! So, if anything, the ratios should be reversed.

Time has proved to us that we cannot hope to obtain the location in West Virginia of a sufficient number of additional doctors to meet our needs at any time in the near future unless we provide a complete medical education in this state. This can be done, and other states of wealth comparable to that of West Virginia are doing it. Again, we have only to ponder what I might term

the ratioactive effects to be fired with the zeal to "grow our own".

We are told that the maintenance of a four-year school of medicine and dentistry would prove to be no hardship to the people in West Virginia and should not in any way affect the normal growth of the other schools and departments of West Virginia University.

We must have unity in the medical and dental professions. We cannot even hope for success unless and until all interested groups decide to support the plan that will best accomplish the objects we have in mind. There should be no controversy whatsoever on location of the medical school.

I am glad that at this 83rd annual meeting of the West Virginia State Medical Association all of the members have agreed upon a plan of action. Now, with the aid of the dental profession and other affiliated groups, we will have some chance to obtain an initial appropriation that will in the next few years spell out for us a magnificent medical center in this state. We must have courage to do what we believe is right, and I have no fear for the success of any enterprise which we, as a profession, support 100 per cent.

REORGANIZATION PLAN NO. 27

We have met and won two skirmishes with the small group in Washington that persistently wages a battle to beat down medicine and establish a welfare state in this country, one that is destroying the effectiveness of the profession in England and other countries. West Virginia has done her part. We have waged a battle that has proved to be successful. I desire here and now to extend again the thanks of the members of our Association to the three Congressmen from West Virginia who bravely withstood the most severe pressure from administration-supported groups and voted early in July to kill Reorganization Plan No. 27.

SOCIALIZED MEDICINE

Socialized medicine must *never* become rooted in this country! We must continue the fight, and I call upon all of our members to support to the fullest extent the campaign of the American Medical Association to awaken the people of this country to the need for continued watchfulness and prompt action when danger arises.

As a conditioning measure, I urge a more active participation by individual doctors and their friends in political affairs. We approach the next round of the battle with the bureaucrats without fear and with full confidence of continued success. The opposition probably will not be heard from again during this session of the Congress, but we may expect the reopening of the campaign against the medical profession when the schemers have agreed upon their 1951 approach.

RURAL MEDICAL CARE

The establishment of community health centers is one of the many ways by which we can improve the health of our people by extending medical aid to areas far removed from hospital facilities and communities populated with a sufficient number of doctors. A plan similar to that in North Carolina should be feasible in this state, with the building and establishment of rural health centers which are moderately equipped and available to all doctors in that particular area, with certain of the doctors assuming the responsibility of the clinic on certain days. This would lead to more prompt and more efficient care for all.

We must continue our efforts to extend medical and hospital services through the extension of voluntary nonprofit service plans.

Our contact with rural groups must be continued, and I strongly advocate an annual, and possibly a semi-annual, rural health conference. Rural groups without exception have shown an interest in the extension of medical care, and I urge that we continue our efforts to solve this most difficult problem.

INCREASE IN ANNUAL DUES

Experience proved to us that a roundtable discussion of problems of medical care could accomplish much in a meeting with representatives of the press and the radio. Funds are needed to operate the Public Relations Committee which assumes the management and responsibility of such discussions, and more will be needed from now on. In the light of this need, consideration had to be given to an increase in dues so that we will not have to operate at such a close financial level each year. With an organization such as ours, this should not be necessary. When dues are increased from $15 to $25, as recommended by the Council and the Committee on Revision of Constitution and By-Laws, it would seem only reasonable to dispense permanently with the registration fee for annual meetings.

EMERGENCY CALL SYSTEM

The round-the-clock emergency call system is proving to be a success. Such a system could well be established by all of our component societies in all of our cities, large and small. It would be one way of proving to the people of West Vir-

ginia that our profession, by streamlined and modern methods, is undertaking to provide the best medical care possible.

APPRECIATION

For myself, being President of the West Virginia State Medical Association has been a delightful and vivid experience. The many new friends that I have acquired in this connection during the past year can be counted as among life's blessings.

As a general practitioner, with the average amount of interest in our organizational work, I was amazed at the vast amount of intellectual and physical effort expended by councillors, committee members and, last, but never least, the executive secretary's office.

Knowing so little of my duties and obligations upon being inducted, I necessarily had to depend a great deal upon our Council and numerous committee members. I gladly take this convenient occasion to thank each and every one for his courteous support and unfailing willingness to help. It has been easy to work with a group no member of which I can honestly say ever refused a request for help although it involved time and inconvenience without compensation.

Nineteen-fifty has been a busy year for us; 1951 will be busier. As doctors, we must continue forward. It is dangerous to stand still while the rest of the world is moving.

ALL-TIME HIGH LIFE EXPECTANCY

Statisticians in the Metropolitan Life Insurance Company have reported new information that was most encouraging. They found that life is longer in the English speaking and Scandinavian countries; women live longer than men practically everywhere in the world except India and Russia which are at least two generations behind the United States in longevity.

The most reecnt data in longevity comes from New Zealand (1934-1938) where the expectation of life at birth is 67 years—the level reached among white persons in the United States in 1945. In Australia, it was 65.3; the Netherlands, 66.5, and Denmark, 66.7. In Germany, the figure was 61.4 in 1932-1934 which was practically the same as for the United States near that time.

As always, women outlive men, especially in countries where the standards of health are high. The exception, of course, is India where health conditions are probably the poorest. The most recent bulletin from the Federal Security Agency reveals that the average length of life of white women in the United States has reached a new high of 71 years; the average for white men is 65.5 years. These were based on 1948 death rates. There is no ground for arguments relative to our health situation.—Illinois Medical Journal.

HIGHLIGHTS OF PSYCHIATRY: PAST, PRESENT, AND THE OUTLOOK FOR THE FUTURE

By G. D. JOHNSON, M. D.
Huntington, W. Va.

In consideration of the subject, we note only the ideas and observations of the past, correct or fallacious, which actually contribute to the present state of knowledge. In chemistry the ancients knew of atoms. It is Dalton's concept of the atom that chemistry has followed through the years. Likewise, Einstein began his book, "The Evolution of Physics", with Galileo and disregarded, for example, Aristotle, whose ideas of motion retarded the development of physics; and, according to Einstein, the discovery and use of scientific reasoning my Galileo was one of the most important achievements in the history of human thought, and marks the real beginning of physics.

The application of the scientific method in psychiatry is of even more recent origin and our historical obligation for tribute to the great men of the past is still more limited than in the cases of chemistry and physics.

Ideas and observations in psychiatry which have a real influence upon our present knowledge do not reach further back than 150 years. In fact, most of our knowledge has been developed only within the past 50 years. In a sense we are more fortunate as expressed by an American lady inspecting an old church in Italy. Their guide, describing the altar, stated that the center portion came from the 14th century, the picture from the 13th century and the sculpture from the 12th century. Upon hearing this, the American lady whispered to her friend, "Goodness! I'm glad we don't have so many centuries in America." But we give credit to Pinel for introducing, in 1783, a more humane attitude toward the insane, and this marks the real beginning of psychiatry.

Kraepelin's system of psychiatry was a descriptive type concerning itself mainly with the delineation of different disease pictures and their typical courses. It developed during the last century, while psychiatric treatment, which is based on the knowledge of the nature and cause of mental disorders, is evolving only at present before our eyes. Our efforts to achieve a causal understanding and cure of mental disturbances are widely varied. They cover a large range, from biochemical research to the psychodynamic and the sociologic approaches. All are etiologically oriented and apply controlled methods of scientific observation and reasoning. This etiologic orientation, the understanding of the causes and nature of mental illness in contrast to the previous merely descriptive approach, is one of the con-

spicuous features of present day psychiatry. Consequently, the mere custodial care of the mentally disturbed patient of former days is giving place to attempts at treatment based upon eiology.

The ancient Greek physician recognized the mental activity as the function of the central nervous system but this function was more concretely recognized only by the medical scientists of the 18th century, and this opened the way to the anatomic and physiologic study of the brain which serves as the scientific basis of psychiatry. Virchow's development of histology culminated in cellular pathology showing that every disease of the soma is the result of disturbed cell function and could be recognized by the microscope.

Most of our great scientists were not psychiatrists but anatomists and their histologic knowledge of the brain can not be applied even today to the understanding of disturbed mental function. Their vision of constructing a bridge between the brain and the mind, between psychiatry as the science of disturbed mental activity and brain anatomy and physiology, has not at this time been accomplished. Virchow's principle did not prove as effective in the field of mental diseases as in other fields of medicine. The major disturbances of schizophrenia and manic depressive psychosis could not be identified by the microscope. The brain of a patient whose external behavior and emotional reactions conspicuously differed from those of the healthy person did not reveal any consistent deviations even under the most exacting scrutiny. The same was true of many other psychiatric conditions such as psychoneurosis and behavior disorders.

Psychiatry's sister branch, neurology, succeeded in correlating the disturbance of many complex functions with disturbed anatomic structure and while neurology dealt with isolated functions of the nervous system, it developed into the most exacting diagnostic branch of medicine. It was not until general paralysis, long suspected to be caused by syphilis, could be explained from tissue damage in the central nervous system, that advancing psychiatry eventually ranked with other medical specialties, and the discourse of Noguchi on the microorganism, Treponema pallidum, in the brain of the general paretic opend the way fort he first time in the field of psychiatry for an etiologically oriented therapy. A disease consists of the faulty funetioning of an organ. This faulty functioning is based on a damaged cell structure which is recognizable under the microscope. The causes of the damage are various infections; chemical stimuli, such as poisoning; or mechanical causes, such as fractures and contusions; in addition, we must remember aging, the chronic disease of all living organisms, consysting of progressive degeneration of the tissue. Up to the time of Ehrlich's chemotherapy of postsyphilitic conditions, psychiatry consited in custodial care, and Ehrlich's salvarsan contribution gave more than anything else to the prestige of psychiatry.

Psychiatry probably would have become a branch of medicine similar to internal medicine, based on pathologic anatomy and physiology, and open to traditional methods of treatment had it not been for the important group of schizophrenic disturbances in which a profound disintegration of the personality occurs without any discernible organic change, and for the even larged group of psychoneuroses in the second decade of psychiatry.

It did not fulfill these expectations but the rest of medicine had to discard the exclusive somatic approach and borrow a new point of view from psychiatry. It was not, therefore, that psychiatry became converted to an exclusive organic point of view but, rather, that medicine began to adopt an orientation which originated in psychiatry, the so-called somatic point of view.

In spite of success such as the explanation and cure of general paralysis and myxedema with the traditional methods of medicine, the majority of psychiatric conditions, the schizophrenic psychoses as well as the psychoneuroses, stubbornly resisted all such efforts. No specific histologic changes were found in those cases. The histopathologic, bacteriologic and biochemical attempts at the solution of the problem of scizophrenia and other functional disturbances of mind continued unabated in intensity until in the last decade of the past century a completely novel method of investigation and therapy was introduced by Sigmund Freud.

As Galileo was the first to apply the method of scientific reasoning to the phenomena of motion, so Freud accomplished the same thing in the field of the study of human personality. The traditional view that disease consists in a local damage caused by circumscribed injury, bacterial, mechanical or chemical in nature, can not be applied to diseases which develop as the result of the total reaction of the organism as a whole toward its environment. Except for aging, this theory does not give recognition to the fact that the process of life itself, with its sustained strains and continuous wear and tear, may be an important source of disease. Medicine recognized the importance of all kinds of localized, more or less accidental, damages caused by bacterial infection, chemical poisoning, or mechanical injury. It would not explicitly recognize, except in the obvious process of aging, those continuous tax-

ations of the organism which are an almost unavoidable part of life itself. Medicine became divided into specialties and forgot about the organism as a unit. It forgot and neglected all those sources of disease which affect the organism as a whole during its struggle to overcome the hardships faced in the difficult business of living. These difficulties consist in assuring gratification to the subjective needs of the organism which requires a constant adaptation to environmental conditions and this adaptation is the function of the central nervous system which we call in man "personality" and which is but the sum of these integrated reactions of the total organism to its environment. The personality disorders have their origin in the repeated daily emotional influence to which the person is consistently exposed throughout the growing up period, in fears, resentments, rivalries and all kinds of emotional frustrations which arise in everyday contacts with other human beings. These influences can not be studied by the usual methods of medicine. Their effect can not be detected by palpation, by optical inspection either by the unaided eye or by the microscope, or by the thermometer. They can be studied only by methods specifically suited to the study of human relationship, that is to say, by psychologic methods.

And so, there has been a thorough revision in the technic of treatment, and psychiatry, the science of the sick person, is becoming the concern not only of the whole medical profession, but by the sick person himself and has made more progress in the past few years than has any other branch of medicine. Both World War I and World War II contributed a great deal to psychiatry and the adjustment of diagnosis and treatment of psychiatric conditions. We are not able to treat effectively many of the numerous mental illnesses, for not all psychoses are curable any more than are all cancers curable. The psychiatrist can no more tell what causes schizophenria in which condition the patient withdraws into a world of fantasy all his own, or the manic depressive state in which the patient swings from abnormal peaks of elation to subnormal depths of depression, than the physician can describe the cause of cancer. But, even in the cases in which the mind disintegrates for no apparent reason, psychiatrists do remarkable work. For example, a scientist noted that epileptics seldom suffer from schizophrenia. He experimented and began to give schizophrenics artificial convulsions on the theory that induced epilepsy might help. And it did. Today one of the standard technics in treating schizophrenic cases is electric shock which produces powerful physical convulsions. These electric shocks are conveyed by placing electrodes on either side of the patient's head and then turning on the current. Records show that this treatment will help, even cure, from 40 to 100 per cent of manic depressive cases and about 25 per cent of early cases of acute schizophrenia.

We use physiotherapy, occupational therapy, psychotherapy, psychology and hypnotism and any other reasonable therapy that will help restore an abnormal mind. Another and more radical treatment is the operation, prefrontal lobotomy, in which the skull is opened and fiber tracts found in the frontal lobes of the brain are severed. An even more recent technic, the transorbital lobotomy, is carried out by driving an instrument shaped like an ice pick under the upper eyebrow and through the orbital socket into the brain fibers and in this way cutting the fiber tracts. There is no single approach to the problem, but all these methods, from psychonolysis, insulin, electric shock, on to lobotomy and general semantics are used when they seem to fit the case and, up to this time, these are the methods of approach and treatment. As new tools and methods are found which are being done before our eyes and which become faster and more effective ways to deal with illnesses of the mind and nervous system, psychiatrists are also directing attention toward preventive psychiatry. Life in our machine age is becoming more and more complex. In our free and competitive society we are at one time, both friends and rivals. We live in "antagonistic cooperation" with our fellowmen. Though our democratic institutions require from us independence in judgment and action, many individuals never attain a state of inner security and thus long for help and leadership. Fears and hostilities, frustrations and thwarted hopes, exaggerated ambitions and discouragement may lead to mental and nervous symptoms or to disturbed human relations. The recognition of these culturally determined factors in the development of personality and neuroses introduces into psychiatry the preventive point of view and represents the connecting link between healing and education. Changed cultural conditions require new, or at least modified, emotional patterns. Child psychiatry is receiving more and better consideration and trained child psychiatrists are in demand as are all psychiatrists in this trying age. We look forward to psychiatric examinations in all schools and to the time when parents will be trained to seek psychiatric help for guidance of their children during the adolescent age and growing up period in meeting and adjusting to everyday experiences in order that emotions such as fear, anger, resentment, guilt or embarrass-

ment which have definite psychologic affects and, later, frustrations, discouragement, hostilities, thwarted hopes and exaggerated ambitions which lead to mental and nervous disorders, may not develop in the life of the individual.

SUMMARY

Psychiatry began with custodial care for those totally incapacitated because of mental illness and up to the last century its progress consisted chiefly in humanizing this care. The next step was to reach a better understanding of the nature of mental disturbances and thus to develop therapeutic measures. Now psychiatry is concerned not only with therapy but also with prevention and we shall continue to progress as the days go by. Largely, prevention is essentially a problem of education which requires a keen understanding of the prevailing cultural patterns, and its objective is to help the individual to adapt himself to these cultural patterns and to meet changing conditions as they arise daily.

TERRAMYCIN

Preliminary clinical trails with terramycin are encouraging. Included among the conditions which have responded in a satisfactory manner are pneumonia, acute follicular tonsillitis and septic sore throat. Urinary tract infections caused by susceptible organisms have likewise responded. In one case of Escherichia coli infection the results were especially satisfactory. The organism was slightly more sensitive to terramycin than to other antibiotic agents.

One patient, critically ill with septicemia due to Bacteroides, made a complete recovery on treatment with terramycin. Another patient with severe multiforme appeared to improve on it. No improvement was noted after the use of terramycin in a patient with herpes zoster.

So far the clinical trials at the Mayo Clinic are only preliminary but it would appear that in terramycin an additional antibiotic which has proved effective in certain infectious diseases has been obtained.—International Medical Digest.

PNEUMONIA AND INFLUENZA STILL KILLERS

The achievements of the past 25 years have been momentous, but they should not obscure the fact that pneumonia and influenza still rank among the leading causes of death in this country, accounting for more than 50,000 deaths a year in the general population.

Further progress can be made in saving lives through the more widespread use of the techniques which have already proved so successful. But the ultimate triumph over pneumonia and influenza will come when methods of preventing these infections are discovered.

If the proper vaccines can be developed, these diseases will certainly be relegated to a minor position among the causes of death in this country. Progress is being made in this direction.—Statistical Bulletin, Metropolitan Life Insurance Company.

6-0 CHROMATIZED GUT IN WOUND CLOSURE AFTER CATARACT EXTRACTION*

By F. BRUCE FRALICK, M. D.**
Ann Arbor, Michigan

The use of sutures to close the corneoscleral wound in cataract extraction has gained in popularity with the development of fine, nonirritating suture material and suitable needles, until at the present time some form of suturing of the wound is used almost universally in this country. When sutures are used, irrespective of the manner of insertion, their purpose is manifold.

We use sutures (1) to approximate the corneoscleral incision until healing has taken place, thus hoping to lessen postoperative wound separation, iris prolapse and astigmatism, (2) to prevent overriding of one margin of the incision on the other so that one face is held abutted against the other over its entire thickness, (3) to avoid side slippage and thus no buckling of the cornea which would produce an uncorrectable irregular astigmatism and allow iris prolapse, (4) to provide more liberty of movement on the part of the patient and thus lessen hypostatic pneumonia and improve the general well being of the patient and (5) to provide a sense of security for the operator that he might not otherwise enjoy.

There is considerable discussion as to whether the sutures should be placed before or after the lens extraction. This seems to depend largely on the methods used and the dexterity of the operator. The McLean type of incision and placement of sutures across the partially penetrating incision line is an example of preplacement of sutures. Preplaced sutures have the advantage over postplaced in that they are more likely to be placed exactly across the incision with the least side displacement, overlapping or eversion of the margins of the cut surfaces. Should vitreous present, the wound may be closed to prevent further vitreous loss that might attend the insertion of additional sutures at this time. The preplaced sutures do clutter up the incision line by tending to be in the way during the section and lens delivery. Nevertheless, the advantages of preplaced sutures, in the opinion of many, far outweigh their disadvantages.

Postplaced sutures, or sutures placed after the lens is extracted, offer a serious mental hazard to many surgeons. Kirby long has been a champion of this method and certainly his results would make us think highly of it. However, most sur-

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**From the Department of Ophthalmic Surgery, University of Michigan.

geons have the natural impulse to close the wound as soon as possible after delivery of the lens. It is their feeling that the more manipulation undertaken at this stage, the more likely the patient to become unruly, and vitreous loss occur. The passage of the needles and sutures through the tough cornea and sclera after the lens has been delivered may constitute trauma sufficient to lead to complications. If vitreous follows the lens, the placing of sutures often leads to further vitreous loss. Some surgeons use a combination of preplaced and postplaced sutures in their cataract surgery. By placing one or two preplaced sutures above, and an additional postplaced suture on either side, it is possible to combine the advantages and obviate the disadvantages of either method. Whatever the method used, the primary purpose of sutures is to promote prompt and accurate wound healing.

Within the past year, the understanding of the physiology of wound healing has been greatly augmented by the knowledge gleaned in other fields through the experimental use of adrenocorticotrophic hormone (ACTH) and the steroidal hormone, cortisone. For a long time surgeons have known that there is a lag or latent period of wound healing in which a period of time is required to initiate the processes leading to fibroblastic fusion of the wound edges. It has been known that very shortly after the corneal section is made there is a weak union of the margins of the wound by fibrin. In many eyes the anterior chamber is reformed in part at the completion of the closing of the wound. Almost simultaneously with the outpouring of fibrin is the start of the lytic phase during which dead tissue is removed. This phase should not be prolonged in a well executed corneal section, since the least possible damage to tissues is encountered and there is very little bleeding. After about four days there is an ameboid movement of wandering fibroblasts, polyblasts and histocytes into the fibrinous zone of the incision. The fibroblasts in contact with fibrin have a tendency to elongate and grow along the fibrils into the central plasma mass of the wound to take part in the organization of the clot.[1] Following these changes endothelial buds grow out from the margin of the wound to form granulation tissue.

The lag or latent period of wound healing is now explained in part by the effect which ACTH or cortisone plays upon the inhibition of fibroblastic proliferation. It has been shown that wound healing does not take place in an individual receiving ACTH or cortisone but that when these substances are withdrawn, healing does take place. The same state of affairs exists in cataract or other surgical procedures. The surgery is a shocking mechanism to the body which sets up a chain of reaction similar to those produced in clinical shock wherein the anterior pituitary puts out an adrenocorticotrophic hormone (ACTH) which activates the adrenal cortex to hypertrophy in its attempt to excrete an excess of cortisone. Just how cortisone affects body cells to change their metabolism is not yet fully explained, but one of its many effects is an inhibition of fibroblastic proliferation. This is now the explanation of the failure of wounds to heal in Cushing's syndrome in which we find hyperplasia of the anterior lobe of the pituitary and adrenal cortex. It would also dictate that no patient receiving ACTH or cortisone should be operated upon for cataract or any other condition until the hormone therapy has been discontinued and its inhibiting effect on the anterior pituitary erased.

During this lag period of healing the wound should be held together with sutures. About the shortest possible 'lag period' occurs in cataract incisions since here we have minimal shock to the individual, strict asepsis and an atraumatic and nonhemorrhagic wound with relatively good blood supply. The lag period for incisions in general is about four days. Even though the latent or lag period for fibroblastic proliferation is four days or less in corneoscleral incisions, the wound is not strongly united by maturation of the fibroblasts and endothelial cells engaged in the fusion of the wound surfaces for some time after this, as evidenced by the fact that most anterior chamber hemorrhages occur between the fourth and sixth postoperative days.[2]

From the foregoing discussion we can conclude that any fine suture material which is relatively nonirritating and which will approximate the wound margins for five to seven days is suitable for cataract wound closure. It is not generally appreciated that suture material of any kind does not actually hold the tissues firmly together for more than five to seven days. The compressed corneal and scleral tissues enclosed in the loop of suture slowly undergo degenerative changes through decreased blood supply and thus the suture adds nothing to the integrity of the wound after this time. Whether the wound separates subsequent to this period of five to seven days and results in an anterior chamber hemorrhage depends entirely upon how rapid and complete has been the proliferation of scar tissue between the two margins of the incision. The type of suture material used, whether absorbable or nonabsorbable, will not prevent wound separation after this period. Care should be taken that the margins of the wound are not sutured so tightly that tension ischemia results. Tension ischemia

produces premature sloughing of the tissues inclosed in the suture and thus the wound margins are not held in approximation during the early stages of wound healing, when they are needed.

Certainly 6-0 silk sutures fulfill the requirements for a suitable suture for cataract surgery, except that the nonabsorbable sutures must be removed. Most patients are apprehensive about the time when incisional sutures are to be removed. Actually, when it has been accomplished, they are surprised how little discomfort attends their removal. Such apprehension on the part of the patent, whose eye is somewhat congested and thus cannot be adequately anesthetized, is likely to result in his wincing at the time of removing the sutures thus causing anterior chamber hemorrhage from wound rupture. These complications can be prevented in one of two ways: (1) If silk sutures (6-0) are used, they should not be removed for at least two weeks and then only if the eye is relatively white and the patient cooperative. Often they will have fallen out of their own accord. (2) An absorbable suture may be used.

Relatively little has been written about the use of absorbable sutures for closure of the wound in cataract surgery. Davis[3] advocated the use of 5-0 plain surgical gut which he used to close the corneoscleral wound. He buried the gut beneath the conjunctival flap. He found that all signs of the catgut had disappeared at the end of a week. He advocated placing the suture after making the section with the knife or keratome and before delivery of the lens, since he found passage of the many needles and sutures through the tough cornea and sclera not easy and that care was required in order to avoid undue trauma.

Hughes, Guy and Romaine,[4] in 1944, published the only additional paper on the use of surgical gut for this purpose. They carefully compared clinically and pathologically the reaction in the tissues caused by 5-0 plain and 5-0 mild chromic surgical gut with 6 and 8-0 silk sutures. They found that the 5-0 mild chromic gut was absorbed in twelve days and caused considerably more reaction in the eye generally than did silk. The sutures were not very flexible and tended to get in the way of the surgeon. It was their feeling that 5-0 mild chromic gut was not suitable for cataract surgery.

The 5-0 plain surgical gut was absorbed in four to five days and caused practically the same reaction in the tissues as 6-0 silk. When soaked for five minutes in 5 per cent glycerin solution the sutures were quite flexible. From their point of view the 5-0 plain surgical gut was satisfactory for cataract surgery, thus agreeing with Davis.

I personally feel that a suture which is absorbed in four to five days is inadequate for cataract surgery since it does not sufficiently cover the lag period of wound healing. The wound is not firmly united with scar tissue at this time and too often undue strain will result in wound separation. An ideal suture would be one which would have the qualities of 5-0 plain gut and, in addition, would hold the tissues approximated for from five to seven days. It was for just this reason that we were happy when we were presented in February, 1946 with an unlimited supply of 6-0 mild chromic surgical gut for clinical evaluation. Since that time we have used this suture routinely in over 700 cataract extractions on the private service and in about an equal number of cases on the clinic service.

Many improvements have been made and still more must be made before the best material is available. The amount of chromatin has been increased to decrease the rate of absorption. This his not materially increased the reaction in the eye, but has made the suture more in contrast with the tissues, and they are still unabsorbed but loose when the patient leaves the hospital on the tenth day. The tissues are approximated the desired five to seven days to tide over the lag period of wound healing. There is no more reaction observed with the 6-0 mild chromic gut sutures than is usually found with 6-0 silk, and the sutures do not have to be removed. The needles have been made stiffer, sharper and smoother, but the manner in which they are swaged on the gut is still defective in that an end of gut often projects from the side of the needle, making it anything but atraumatic.

Recently, we have been sent 6-0 mild and 6-0 medium chromic surgical gut on a fine eye needle by another manufacturer. The needles are better in every way than those provided by the other supplier. The gut is even in caliber, but only the mild chromic gut gives minimal reaction in the eye comparable with that obtained with 6-0 silk. The mild chromic gut shows signs of absorption when the patient leaves the hospital at the end of ten days and is never visible on his return two weeks later. The medium chromic gut on the other hand often is in place but largely absorbed when the patient returns two weeks following discharge. There often is a little corneal scarring at the site of the knot and definitely more reaction about the suture than is present with the mild chromic gut. The medium chromic gut does not become sufficiently flexible when soaked in 5 per cent glycerin solution up to the time of use and thus has a tendency not to remain draped out of the operator's way when he is making the section or lens delivery. From our limited experi-

ence with these latter two chromic gut sutures, we conclude that the medium chromic gut has no advantage over the mild chromic gut and, with its tendency to produce more reaction, is less suitable for cataract wound closure.

SUMMARY

As far as can be observed 6-0 mild chromic surgical gut from either manufacturer is ideal for closure of the corneoscleral wound after cataract surgery. It is nonirritating. It is durable enough to approximate the wound for more than the four to five days comprising the lag period of wound healing before the granlation tissue is sufficiently strong to keep the wound intact. If soaked in 5 per cent glycerin solution up to the time of its use, it remains moist and pliable during the period of operation. Lastly, the gut sutures never need be removed.

Six-0 medium chromic gut was found to be unsuitable for cataract wound closure because (1) it produced too much reaction in the tissues, (2) it was too stiff and (3) it did not approximate the tissues any longer before it loosened in the tissues than did the 6-0 mild gut or 6-0 silk.

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DISCUSSION

Doctor Fralick is to be complimented on this timely paper and apt discussion of the subject. His figures of cases handled are surely sufficient to justify conclusions drawn from his experience, individual and associated.

The changing from a satisfactory to an even more satisfactory material is a delicate procedure, to say the least. Habits which have become set after years of practice seldom are conducive to change in adopting advances, regardless of merit. Honest admission of faults and difficulties, with open discussion as to their elimination, is always a healthy sign.

Therefore, I shall discuss some features and raise some questions which may be helpful in further handling the all-important factor, the patient.

My instruction was under the guidance of the late E. C. Ellett, M. D., one whom I consider a past master in cataract surgery. A large percentage of his cases included corneoscleral suture, fine black silk being used. His faultless technic, with able assistance, was a joy to watch but then not fully appreciated.

Recently I made a survey of the majority of those doing eye surgery in West Virginia and am pleased to report that all answered my questionnaire. I was agreeably surprised to learn that 100 per cent do use cataract sutures. Only three have used material other than silk. The experiences quoted with reference to gut material, for explained reasons, have not been satisfactory, or at least have been less satisfactory than those with reference to fine silk. Doctor Fralick's paper may help to remove some of the objections.

As to the placement of sutures, I believe it is necessary to make one point clear. If iridectomy is done, or what is called "the combined operative procedure," the ease of preplaced sutures rather than postplaced ones is, in our opinion, highly preferable, and in the hands of the occasional operator certainly much safer for both patient and operator. The tendency of the day is to preserve a round pupil but unless the best of technic is adhered to, the number of complications rises.

While taught to do the straight keratome incision, we use the angular keratome incision and enlarge with scissors. We believe that the multiple uneven areas thus produced have contributed a large element of success in eliminating delayed healing and the production of high degrees of astigmatism. We feel that there is less slippage of the wound edges which accounts for these factors. Iris inclusion also has been largely eliminated.

The essayist has not enlarged upon cases of fluid vitreous. Certainly in such cases preplaced sutures are a godsend, regardless of type. Here, too, the overlapping of wound edges can become a most serious problem.

Planned placement of suture material plus equally painstaking placement of the loops out of the field of operation, prior to incision, is of extreme importance. Even under thorough scrutiny before, it is embarrassing to find one has, on occasion, cut a most carefully placed suture. This damage is not irreparable but it is not corrected

with the same ease or dexterity, ofter because of a mental hazard more exaggerated in the inexperienced hand.

The essayist has not dwelt on the conjunctival sutures alone. These are the most easily placed and removed. From the standpoint of infection, they have, in our experience, been the safest. In such procedures complete closure of the wound is also safer than partial closure. The combination corneoscleral and conjunctival closure is even better, all factors considered.

The question of needles is very important. Also, it is necessary to inspect the points personally. One may find sufficient evidence to discard a needle now and then, due to poor workmanship, or find himself working under difficulties because of the omission of preoperative inspection. This factor is especially important in the general hospital where crews and even supervisors change unexpectedly.

The old Moria needle had one of the best points it has been my experience to use. Certainly the newer needles have proved a boon to neater and easier surgery in the category under consideration.

While the author has mentioned the tying of the sutures, the importance of not tying them too tightly cannot be overemphasized.

We have found that careful toilet of the wound before closing the eye is most important. A thorough inspection before tying, or even after, with replacement of iris or removal of iris tags is also essential. Not to be overlooked are the zonular fibers overlying the wound edges. In our experience, iris pigment alone may delay healing.

While we have had no experience in the use of fibrin preparations by themselves, they have been recently advocated. Perhaps in the future, by usage of such materials now in experimental stages, elimination of sutures entirely will be possible.

The use of anesthesia in this discussion is very important. Adequate and safe closure becomes more important when a general anesthetic is administered. Thomas, of Pittsburgh, we are informed, uses pentothal sodium. Not all reactions from such are peaceful, at least in the hands of less experienced anesthesiologists. Then, too, there are those cases in children in which adequate closure as well as suture removal are real problems. Certainly here the nonnecessity of removal of sutures will receive advocates.

Delayed hemorrhages can be partially reduced by elimination of curiosity and overzealous care in dressing. Delayed use of drugs also brings up important questions in evaluation of the subject under discussion. Also, the activity of the patient and the eagerness to reduce hospital days need further elaboration. We find that caution and a good cooperative patient will, in many cases, prevent unforeseen headaches to doctor and patient. The noncooperative foreign-born patient is unpredictable in our hands, regardless of technic and material.

We can heartily agree that suture removal even under ideal conditions can be very trying to all persons involved. However, care and patience will go a long way inaverting accidents incidental to this procedure.

Careful explanation to the patient will do much to allay his fears over any symptoms due to buried sutures. Some patients never voice objection to minor sensations of scratching, et cetera, while others can worry themselves sick over the same lesser details.

Again, we thank Doctor Fralick for his presentation and ask him to remind his colleagues of this delightful spot where we gather twice yearly.

ALCOHOLISM SYMPTOM OF DISEASE

The alcoholic problem is, and has been, a challenge to the medical profession and especially to the field of psychiatry; certainly, thus far, we can lay no claim to fame for having conquered it.

It is my opinion, and there are few who will take issue with the statement, that every alcoholic is a psychiatric case. It is not always possible to discover the reason that an individual drinks to his detriment, but there is always a cause. Alcoholism is simply the symptom of the disease. Thus far, the results of the therapy are disheartening.

The problem is an increasing one and the prevention, as well as the treatment, should have the active support of every branch of medicine.—R. Finley Gayle, Jr., M. D., in Virginia Medical Monthly..

MASS CHEST X-RAY SURVEYS IMPORTANT

The medical profession of large areas of the United States has become exceedingly alert and active in the diagnosis of tuberculosis. It is amazing how many physicians are using the tuberculin test, making x-ray inspections of the chests of adult reactors, not only once, but periodically, and completing the examinations for all whose films reveal abnormal shadows. Thus in many places they are keeping the population reasonably well depleted of unsuspected cases of clinically significant tuberculosis.

The ultimate goal will be attained when physicians everywhere assume the responsibility for tuberculosis control in their respective communities. Until this occurs mass chest x-ray surveys can play such an important role in our cities as to deserve full support of the medical profession.—J. A. M. in Diseases of the Chest.

LOEFFLER'S SYNDROME*

Transitory Pulmonary Infiltrations and Eosinophilia: Case Report

By G. E. IRVIN, M. D.
Welch, W. Va.

This subject is timely in view of the important role that allergy plays in the predisposition to or actual causation of disease conditions that confront us in daily practice. We have come to recognize both clinical and pathologic evidence of an altered tissue response based solely upon allergic mechanisms. The clinical observation of roentgenologic and other changes occurring in an allergic individual prompted reporting an additional case of so-called Loeffler's syndrome along with some discussion correlating a few of the more recent clinical, pathologic and experimental investigations which bring out the previously minimized role that allergy plays in its pathogenesis. There is accumulating evidence that many conditions believed to be disease entities probably are closely related, the clinical manifestations depending more on the organ or organs where the allergic reaction is most pronounced and the nature of the allergen.

William Loeffler, professor of medicine at the University of Zurich, was among the first to recognize the occurrence and importance of transitory lung infiltrations. He[1,2] reported five cases in 1932 and later another larger series of a syndrome which he believed to represent a clinical entity. Since then the concept of so-called Loeffler's syndrome has been broadened by more widespread interest and accumulated evidence so that it no longer remains as a distinct entity. Loeffler recognized the probable allergic nature of the condition. Though Loeffler's cases were all from Switzerland, reports appeared in the literature from other countries concomitant with the increasing use of x-ray studies. Most of the reported cases came from the central European countries while a few appeared in the American and British literature. By 1944, Peabody[3] could find only twenty-five cases in the American literature, some of which he considered not authentic according to Loeffler's criteria. Similar conclusions were arrived at in a later survey by Tocker.[4]

Any case presenting bizarre lung shadows with an increased blood eosinophilia has been labeled Loeffler's syndrome; these have been reported also as eosinophilic pneumonia, allergic pneumonia, Loeffler's pneumonia, allergic edema of the lungs, et cetera. Discrepancies are to be expected in view of the lack of general agreement as to the causation and pathogenesis of the syndrome. This state is due largely to the dearth of pathologic material available for examination and study because of the inherent benignity of the condition. Very few opportunities have existed for autopsy examination in these cases, especially those that fulfill the strict criteria outlined by Loeffler.

With these brief introductory remarks let us consider the syndrome in more detail.

CLINICAL FEATURES

According to Loeffler's classical description, the syndrome consists of three major features: (1) fugitive shifting pulmonary roentgenologic changes of marked variability, (2) concomitant but variable blood eosinophilia and (3) mild clinical course of short duration with x-ray findings out of proportion to the physical disability. The x-ray findings are a striking feature of the syndrome, and Loeffler emphasized the fleeting migratory character of the infiltrations that develop and disappear in three to ten days. The shadows are unilateral or bilateral, small or large, single or multiple, homogeneous or spotty. They may appear at any site or have any extent, and cavitation is not seen. Occasionally pleural effusions develop, though usually they are not large enough to warrant thoracentesis. Fine star-shaped shadows may be left after resolution of these infiltrates.

The blood shows a definite though variable eosinophilia in all cases, ranging from 10 to 60 per cent. The leukocyte count may be normal or moderately elevated. The degree of eosinophilia does not necessarily parallel the fluctuations in the pulmonary infiltrations; however, the maximal eosinophilia usually occurs at the height of the infiltrations. Study of the peripheral blood smear reveals eosinophils of the mature type with the other elements not particularly affected. The sedimentation rate is moderately elevated in most cases.

These patients are usually not too ill. In fact, over 25 per cent of Loeffler's cases were discovered upon routine x-ray examination. Fever may be low grade or absent. A cough is common, often productive of thin mucoid sputum showing numerous eosinophils. Chest pain occurs if there is pleural involvement with effusion or friction rub. Usually the physical findings are limited to scattered moist rales upon auscultation, though asthma is not an essential part of the syndrome. The patient may complain only of malaise and loss of appetite. The prognosis is uniformly favorable. Some seasonal incidence was noted in Loeffler's cases, as most occurred during July and August. All were adults, two-thirds of the number being males.

*From the Department of Medicine, Grace Hospital, Welch.

Since Loeffler's first publication, the concept of the syndrome has been broadened to include many conditions with atypical features. In several cases the authors[5,6,7] have noted chronicity, recurrence and even fatal outcome. In an attempt to clarify some of the confusion surrounding the grouping of these variants of the original syndrome, Kartagener[6] classified them according to the severity and duration of symptoms, as follows: (a) cases pursuing an acute but mild process of short duration (Loeffler type), (b) cases showing an acute septic-like process with persistence of the pulmonary infiltrates and (c) cases with mild but prolonged symptoms.

The differential diagnosis in instances of suspected Loeffler's syndrome usually is limited to those conditions or diseases known to be associated with a high blood eosinophilia. As we shall learn presently, this includes tuberculosis, brucellosis, Hodgkins disease, virus and atypical pneumonias, helminthiasis, sulfonamide and serum sensitivity, pariarteritis nodosa, sarcoidosis and other allergic disorders.

The treatment of Loefflers syndrome has been along symptomatic lines only because of the inability to demonstrate a specific etiologic agent in most reported cases.

PATHOGENESIS

In Loeffler's cases pulmonary embolism with infarction, bronchial asthma with partial atelectasis, tuberculous infiltrations and abortive pneumonia were considered. Tuberculosis was not demonstrated in any of his cases during the acute episodes (though pulmonary tuberculosis developed in one case a year later). In fact, 35 per cent had negative tuberculin reactions; however, Loeffler felt that some of his cases were related to tuberculosis and the differential diagnosis was difficult to establish without serial x-ray studies. Parasitism was entertained as a causative agent in view of its frequent presence, especially ascariasis. Loeffler considered helminthiasis not a likely explanation except in a few instances. In a more recent communication Loeffler and associates[8] reported results of guinea pig experiments relative to the etiologic role of ascariasis; they were able to reproduce the syndrome exactly and confirm observations of Muller[9] and others. Loeffler also considered anaphylaxis and finally suggested that the etiology probably would be found in manifold causal agents which initiate allergic pulmonary reactions. He drew an analogy to erythema nodosa which may at times represent an exudative phenomenon as an allergic manifestation of visceral tuberculosis without the actual presence of the infecting agent; thus, the lung process was likened to a tuberculid.

Though Loeffler did not particularly stress allergic factors in the pathogenesis of the syndrome, Maier,[10] in reviewing 100 cases from Loeffler's clinic, noted that 52 manifested some form of allergy, bronchial asthma being most common. In view of the apparent close relationship between asthma and this syndrome one might expect a rather high incidence of transitory lung infiltrations in those suffering from chronic bronchial asthma. Breton[11] stated that it occurs in from 5 to 8 per cent of asthmatics. Most of the available autopsy material has come from patients known to have suffered from asthma in a rather severe form. Von Meyenburg,[12] in 1943, reported four cases with pathologic study. Three of these patients died accidentally and the fourth died following tetanus. Though none had been studied clinically one was known to have suffered from asthma in childhood. Von Meyenburg felt that the transitory pulmonary infiltrations were pneumonic in type with exudation into the alveoli and interstitial tissue, i. e., an eosinophilic pneumonia. No evidence of tuberculosis or larvae was seen, though granulomas resembling those of rheumatic fever were observed in one case.

Harkavy,[5] in the second of two articles covering intensive study of a special group of fifteen asthmatics, reported four cases which came to autopsy. He ascribed the transitory infiltrations to congestion, edema and thrombi of the small vessels in one case and to infiltration of the alveolar septa with eosinophils, polymorphonuclear leukocytes, lymphocytes and edema in two others. Constrictive pericarditis with eosinophilic exudates in the pleural and peritoneal cavities had developed in 3 cases. Two showed the characteristic microscopic lesions of periarteritis nodosa. The arteries evidently were the site of a hyperergic reaction varying from a simple intimal thickening in some places to a necrotizing arteritis in others. Harkavy felt that this basic hyperergic vascular reaction (together with connective tissue changes) was in keeping with the hypersensitivity concept in discussing the pathogenesis of Loeffler's syndrome; the actual exciting or sensitizing agents may be multiple and of either bacterial (intrinsic) or nonbacterial (extrinsic) origin. The clinical features depend largely upon the qualitative and quantitative degree of tissue response so that seemingly separate disease entities may be produced which are in reality merely different phases of the allergic reaction. In the early stages these changes are entirely reversible (as illustrated by Loeffler's cases); however, with repeated attacks irreversible damage occurs to produce a chronic allergic

inflammatory involvement (as illustrated by Harkavy's cases).

Bergstrand,[7] in a comprehensive pathologic study of four similar cases, likewise found vascular and connective tissue changes consistent with periarteritis nodosa and rheumatic fever. He felt that the transitory lung infiltrates were closely allied to so-called rheumatic pneumonia. Finally he drew a parallel between the joint and skin changes in rheumatic fever and the transitory lung infiltrates of Loeffler's syndrome. He concluded that such syndromes as polyarthritis rheumatica, periarteritis nodosa, endomyopericarditis rheumatica and Loeffler's syndrome are morphologic equivalents. The clinical classification and symptomatology of these conditions depend largely upon the location and severity of this antigen-antibody (allergic) reaction.

Baggenstoss and associates[13] published their findings in the case of a 57 year old chronic asthmatic who died three months following an episode of probable Loeffler's syndrome. The patient apparently suffered a recurrence, with heart failure. They found an unusual form of organized pneumonia as well as tubercle-like lesions bearing a superficial resemblance to those of rheumatic fever. In addition vascular lesions of periarteritis nodosa were present. The findings substantiate the feeling that at least in some instances the pulmonary infiltrates are far from transitory in nature. Likewise the vascular lesions in this case, as in those previously cited, point toward an allergic basis for Loeffler's syndrome. The specific inciting agents (allergens) may be very diversified in nature, yet produce similar tissue responses.

Thus, through accumulated evidence, we have arrived at a fairly logical understanding of the pathologic physiology in these cases. However, the final elucidation of specific causal agents remains a problem. There is an ever increasing number of conditions and disease processes known to be associated with transitory pulmonary infiltrates and blood eosinophilia. Alphers[14] suggested division of etiologic factors into two general classes: (1) an extrinsic group associated with plant pollens, drug reactions, et cetera and (2) a more comprehensive intrinsic group associated with infections, infestations, et cetera. In many instances only bronchial asthma is found and usually no specific pollen can be indicted. However, Alphers and Toeker[4] each have reported instances of Loeffler's syndrome occurring during the ragweed season possibly due to the ragweed pollen. Engel[15] reported a seasonal type of Loeffler's syndrome, from Shanghai, associated with the privet plant pollen. Transitory pulmonary infiltrates attending the administration of sulfonamides[16], repository penicillin[17] and various sera[18] have been reported.

The intrinsic group is a large one covering for the most part case reports in which helminthiasis was found to be either associated with this peculiar syndrome, or the suspected causal factor in eliciting it. Reports have cited the following: ascariasis,[19] amebiasis,[20] cutaneous helminthiasis,[21] trichinosis,[22] strongyloidiasis,[23] clonorchiasis,[24] hookworm disease[25] and filariasis,[26] to name only a few. Thus, at least from the standpoint of numbers there is considerable evidence to support the parasitism theory of causation; its supporters stress that the parasite need not always be demonstrable in the stools or sputum during the acute Loeffler's episode. On the other hand, when some parasite is found its eradication is not always accompanied by abatement of the pulmonary and blood changes. An exception to this has been found in so-called tropical eosinophilia. This condition was first reported from India by Weingarten[27] who considered it to be a clinical entity peculiar to that country. Clinically it resembles an atypical Loeffler's syndrome but responds immediately and completely to treatment with organic arsenicals. After Weingarten drew medical attention to this condition, similar cases were reported[26,28,29] in returned service personnel who had served in the tropics. Tropical eosinophilia is believed to be caused by filariasis in most instances. Apley and Grant[29] feel that there is a definite correlation between such conditions as tropical eosinophilia, Loeffler's syndrome, periarteritis nodosa and bronchial asthma; they classify them under the general heading E-P (eosinophilia-pulmonary infiltrate) syndrome. Tropical eosinophilia, therefore, apparently is closely allied to the group of conditions under discussion. Bouronele,[30] after thorough study of nine cases of Loeffler's syndrome, concluded that tropical eosinophilia, eosinophilic leukemoid syndrome and eosinophilic infiltrations of the lung (Loeffler's) represent clinical variants of the same infection whose specific agent is unknown. More recently, Wise[31] reached essentially the same conclusions in comparing tropical eosinophilia and Loeffler's syndrome. However, he emphasized the importance of careful differential diagnosis in view of the different prognosis and treatment of the two conditions. Thus, some eighteen years after Loeffler's original studies and theorizations on this subject, we are forced to conclude that aside from gaining some insight into the pathologic physiology which takes place, the condition remains an allergic pulmonary reaction with probable multiple etiolgic factors which often are of undetermined nature.

CASE REPORT

Mrs. W. P., a 55 year old white woman, was admitted to Grace Hospital for study on June 30, 1949, because of persistent fever, muscular and joint pains, shortness of breath with wheezing and cough, poor appetite, and night sweats of two to three weeks' duration. This patient had been seen periodically in the outpatient department for more than six years. She suffered from recurrent hay fever and bronchial asthma, worse during the ragweed season, but aggravated also by upper respiratory infections. Allergic studies had revealed only mild skin reactions to house dust, orris root and plaintain mixture. The blood eosinophilia never rose above 3 or 4 per cent. Frequent roentgenograms, including one taken three months prior to her present illness, were not remarkable. She had received dust and hapamine hyposensitization therapy with little improvement.

Examination and Hospital Course.—Physical examination revealed a thin dyspneic woman who appeared chronically ill. The skin was warm (temp. 100), dry, and free of pigmentation and lesions. The head and neck were not remarkable. Blood pressure was 110/80. The heart examination was essentially normal. Examination of the lungs revealed scattered asthmatic-type rales with no evidence of consolidation. The abdomen and pelvic organs were negative. The initial hematologic study showed 4.2 M. RBC per cu. mm. with 10.8 Gm. HB and a leukocytosis of 13,000, 52 per cent of which were eosinophils of the adult type. The sedimentation rate was 44 mm. after one hour (Westergren). The urine was negative. A chest x-ray the day after admission showed changes in both apices. Sputums were scanty and negative for acid-fast bacilli on several occasions. Numerous eosinophils were present, however. Repeat blood count one week after admission showed a leukocytosis of 18,500 with 65 per cent eosinophils. X-ray of the chest showed extension of the pulmonary infiltrates with apparent cavitation (figure 1). A second strength tuberculin test using protein derivative was negative. Stools were negative for ova and parasites. An electrocardiogram showed a tendency to low voltage with some slurring and splintering of the QRS complexes; there were no S-T-T changes. A chest x-ray two weeks after admission revealed spreading of the pulmonary infiltrates to involve the left lower lung. During the first three weeks' hospitalization the patient ran a remittent type of fever to 101.5 F. She complained of constant muscle and joint pains which responded fairly well to salicylates. The asthmatic symptoms were never distressing, and gradually abated. She was given courses of antibiotics including penicillin, streptomycin and aureomycin in therapeutic dosage, with no discernible effect upon her clinical course. Repeat x-ray studies revealed clearing of the initial in-

Fig. 1 (July 7, 1949)—Pleural thickening over apices and lateral chest wall. Interstitial infiltrations present in both infra-clavicular areas, more marked on left which shows an area of decreased density suggestive of cavitation.

Fig. 2 (July 25, 1949)—Slight clearing of previously noted infiltrates with new shadows in both costophrenic angles and right mid-lung area. The latter shows a small area of translucence suggestive of cavitation.

filtrates with increased density of new shadows (figure 2). These pulmonary changes began to recede after five to six weeks' hospitalization. The maximal leukocytosis of 23,000 with 72 per cent eosinophils was reported during the fifth week. Blood culture and agglutinations were negative. Concomitant with the receding pulmonary shadows (figure 3) the patient improved clinically. The fever subsided, appetite improved, and the cough became less severe. She was discharged on August 19, 1949, after fifty days' hospitalization and was examined one month later in the outpatient department. Chest x-ray at this time revealed reversion to normal (figure 4). The leukocyte count was 11,500 with 8 per cent eosinophils.

COMMENT

This case is similar in many respects to several others reported previously. The illness came on rather insidiously not having been precipitated by any acute allergic reaction. The patient was having no hay fever symptoms and the asthma had been rather quiescent just prior to the onset of her present illness. Our presumptive diagnosis was pulmonary tuberculosis in view of the patient's general debility and roentgenographic findings of apparent cavitation which developed one week following admission (figure 1). However, repeated sputum examinations were consistently negative for acid-fast bacilli. In addition, a negative skin test to .005 mg. tuberculin (PPD) practically eliminated active tuberculosis

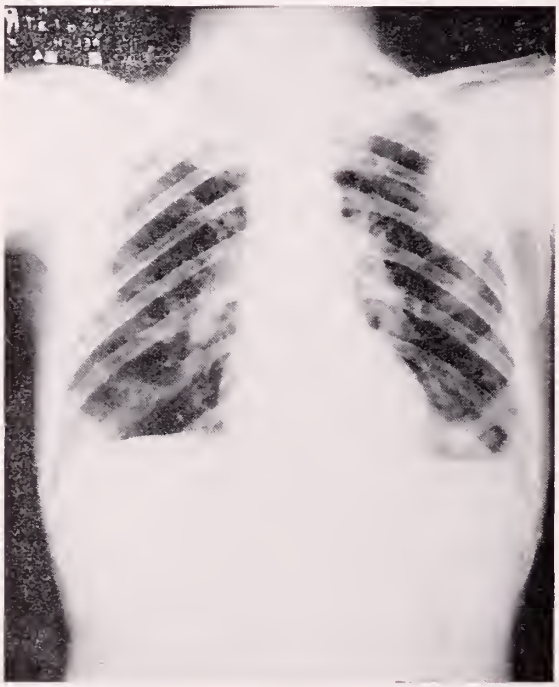

Fig. 3 (August 14, 1949)—Considerable clearing of infiltrates in both lungs and areas of apparent cavitation are no longer suspicious.

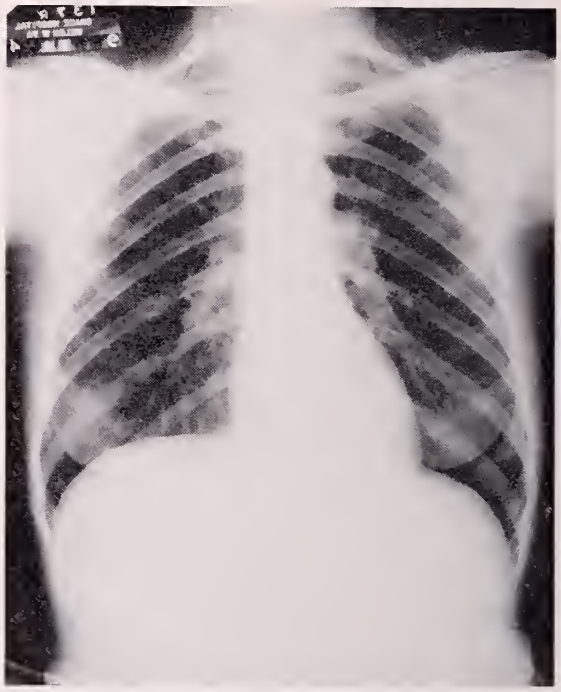

Fig. 4 (September 25, 1949)—Essentially complete clearing of all infiltrates.

as a likely etiologic factor. The subsequent course, together with correlation of other data, permitted us to arrive at the correct diagnosis. Serial roentgenograms were of great assistance in this respect inasmuch as the fleeting and migratory character of the pulmonary shadows is seen in few other conditions. The importance of not relying upon a single x-ray diagnosis of pulmonary tuberculosis has been emphasized repeatedly by others, including Loeffler himself. Karan and Singer[32] reported five instances in which an x-ray diagnosis of pulmonary tuberculosis was made by competent radiologists and invalidated by subsequent studies; two of the five cases probably were examples of Loeffler's syndrome while the other three represented either virus pneumonia or lobular atelectasis. Pirkle and Davin[33] reported a similar experience. Infiltrations, particularly in the upper lung areas, that persist for long periods with little change are at times very difficult to differentiate from tuberculosis. The finding of apparent cavitation in our case is evidently very unusual. Tocker[4] could find only two such cases in the literature, including his own. Aside from being an allergic individual, with asthma, study of our patient revealed no other demonstrable etiologic factor which may have precipitated this episode of Loeffler's syndrome. Blood cultures, routine agglutinations and stool and sputum examinations gave no clues. This patient received most of the available antibiotics and sulfonamides in therapeutic dosage without any discernible effect upon the clinical

course of the syndrome. This fact alone seems to confirm the allergic rather than the infectious nature of the condition. Our case well illustrated the striking disparity between the apparent severity of the pulmonary process and minimal physical findings upon examination. This, of course, is an important characteristic of the classical Loeffler's syndrome. Even more interesting was the rapid resolution of extensive pulmonary infiltrations which could be only upon a reversible allergic basis.

Only in the last few years has the role of hypersensitivity been investigated as a factor in the production of disturbed physiologic processes with resultant reversible or irreversible pathologic changes. Much has been learned from the study and experimental production of periarteritis nodosa. This condition until recently has been considered to be a rare disease of unknown etiology, the diagnosis of which is practically impossible except at autopsy. However, largely through the extensive investigations of Rich[34] and others, it appears that the most likely explanation will be found in a vascular response based upon a state of hypersensitivity. This is borne out by statistical studies on the incidence of allergic manifestations in those in whom periarteritis nodosa finally develops. In a review of 300 cases of proved periarteritis nodosa Wilson and Alexander[35] noted a history of asthma in 18 per cent. Others[36] have reported somewhat higher figures. I have alluded previously to the rather frequent occurrence of periarteritis nodosa along with connective tissue changes in autopsy cases of severe asthma reported as variants of Loeffler's syndrome. Periarteritis nodosa, of course, represents the end stage of a rather severe irreversible allergic reaction involving chiefly the vascular system. In discussing possible etiologic factors in periarteritis nodosa many will be found to be identical with those considered in the genesis of the more benign Loeffler's syndrome. For example, the administration of sulfonamides has been found to be associated with transitory pulmonary infiltrations.[16] On the other hand, there is fairly conclusive evidence available that periarteritis nodosa may result from severe hypersensitivity to these drugs. Furthermore, as reported by Gelfand and Aronoff,[36] there seems to be a definite relationship between the increased incidence of periarteritis nodosa and the widespread usage of the sulfonamides. Thus, there appears to be overwhelming evidence that the basic type of tissue reaction is identical in these E-P syndromes consisting of periarteritis nodosa, polyarthritis rheumatism, Loeffler's syndrome and others. The clinical features depend more upon the chief site or sites of reaction, the degree and duration of reaction, et cetera. The nature of the primary inciting agent (allergen) apparently is not as important as the constitutional allergic predisposition to such reactions based upon a state of hypersensitivity.

SUMMARY AND CONCLUSIONS

Instances of associated pulmonary infiltrates and eosinophilia had not been reported in appreciable numbers prior to the publications of W. Loeffler who reported this condition as a clinical entity of unknown etiology. Later investigations, however, were to disprove this original concept as well as to clarify its pathogenesis to some extent.

The clinical features of the classical syndrome described by Loeffler are discussed together with a tentative classification of such conditions to include those variants of the original syndrome with atypical features.

The pathogenesis of Loeffler's syndrome is founded upon an allergic tissue response of the anaphylactic type based in turn upon a state of hypersensitivity. Pathologic study has revealed this allergic reaction in the lungs to vary from a mild type with congestion, edema and eosinophilic exudate to very severe connective tissue and vascular changes typical of periarteritis nodosa. This reaction may be reversible or irreversible, depending upon such factors as the degree of severity and duration of the reaction as well as the nature of the allergen. The inciting agents (allergens) may be either of intrinsic or extrinsic origin, the definitive demonstration of which is not always possible.

A case history of Loeffler's syndrome occurring in a chronic asthmatic with an interesting series of roentgenographs is presented. This case is an example of the classical type of Loeffler's syndrome in which the allergic pulmonary reaction was of the reversible type.

The most logical conclusion evolving from these studies is that Loeffler's syndrome probably represents merely one phase or subgroup as part of a larger group of conditions which may manifest the E-P (eosinophilia-pulmonary infiltrate) syndrome. Apparently, disimilar conditions such as polyarthritis rheumatica, Loeffler's syndrome, tropical eosinophilia, rheumatic pneumonia, periarteritis nodosa, et cetera, are closely related, the clinical and pathologic manifestations of which depend largely upon the location, type, degree of severity and duration of the allergic (antigen-antibody) reaction. The exact nature of the allergen is not as important as the consti-

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tutional predisposition of the individual to such reaction.

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TEAMWORK IN TREATMENT OF POLIOMYELITIS

Through the years a variety of therapeutic agents have been suggested for poliomyelitis. To date no single specific treatment has been efficacious. The aim of all forms of therapy should be "to relieve pain, to minimize debility, to prevent and correct muscular deformity, and to treat the emotional disturbances which occur so frequently." The final result depends on the team work of many specialists.

The purposes of this medical team of experts should be: utilization of all intact neuromuscular units, prevention or minimizing of all musculoskeletal deformities that would limit the most effective use of these units, training of patient and parents in their responsibilities within the program, and intelligent acceptance of patient and family of ultimate physical limitations.—Ellen Vogel in New England Journal of Medicine.

THE DOCTOR'S RESPONSIBILITY

Doctors have tremendous obligations as citizens. They need to take part in helping a sick society to recover and to aid in the creation of a more stable society. Physicians are as capable of knowing human needs and of understanding human relations as any group in our society. As a doctor-citizen you have it especially within your power right now to play a major part in saving our American Way of Life.—Robt. E. Robins, M. D., in New York Medicine.

TUBERCULOSIS ABSTRACTS*

BCG VACCINATION

The initials BCG stand for Bacillus of Calmette and Guerin. It was named for the two French scientists who, using a potent bovine strain of tubercle bacillus isolated in 1902, were able to show a sharp reduction in virulence of the organism after repeated passage on an artificial medium. This finding led them to consider the possibility of further reducing the virulence of the strain in order to develop a living vaccine which by causing a mild and harmless infection would pertect human beings against the invasion of more virulent organisms.

In 1908, Calmette and Buerin announced that they had developed a strain of bovine tubercle bacilli which had no virulence for cattle. Twelve years later, they reported that this BCG culture was harmless to man. Later studies of groups vaccinated with BCG confirmed this and showed a lowered illness rate and death rate for tuberculosis over varying periods of time in these groups.

This certainty, however, was not immediately reached. Lack of proper controls during the early work done with this vaccine, together with the difficulty of maintaining the fixed nonvirulent strain of the tubercle bacillus, retarded its wide-spead use. Over the years, the resistannce to the use of BCG has been partially conquered, and it is now widely accepted as an effective tool when used in conjunction with other techniques of tuberculosis control.

Misunderstandings

Certain misconceptions about the use of BCG vaccine still persist. First of all, the vaccine is given only to those persons who are negative reactors to the tuberculin test. Over many centuries, the human race has become fairly resistant to tuberculosis. The majority of persons sooner or later become infected with tubercle bacilli and are positive reactors to the tuberculin test. They do not, however, in the vast majority of instances, develop real tuberculous disease. Although a certain immunity is gained through infection with the disease germ, a chance infection with virulent germs is not a satsfactory method of immunization. An infection with mild and harmless strain of tubercle bacilli can be overcome by protective antibodies which may, in time, combat a future invasion of virulent germs. BCG vaccine is designed to strengthen resistance and thereby protect against a disease that might otherwise be disabling or fatal.

Groups to Be Vaccinated

Public health authorities consider it wise to confine BCG vaccination to groups such as nurses, medical students, and hospital personnel who are occupationally exposed to tuberculosis and to those who will be in direct contact with a person who has an open case of tuberculosis.

Vaccination is not undertaken when general weakness, minor infections, measles, whooping cough, eczema or furunculosis are encountered.

BCG Is No Cure

BCG is a preventive measure, not a cure or a method of treating tuberculosis, and is used always as an adjunct to other methods of controlling the disease. Finding cases, isolating and treating them, rehabilitating and returning them to normal lives are the principal methods of fighting this disease. BCG can reduce the number of persons who will become tuberculous, but it can in no way assist in fighting the disease after it has been contracted.

Duration of Protection

At the present time it is not possible to say that BCG provides immunity over any definite number of years. Research will, doubtless, provide us with reassuring answers in the future.

When carefully carried on by experienced physicians, BCG vaccination causes no untoward reaction and promises to protect individuals against tuberculosis. When used as a part of the general tuberculosis control program, BCG provides us with one more means of attack on an age-old disease enemy of mankind. In the war-devastated countries of Europe, the World Health Organization is pushing forward a mass vaccination, the results of which may prolong the productive lives of many persons who, without such protection, would fall victim to tuberculosis.

BCG Vaccination, Howard C. Sewart, M. D., N. Y. State Dept. of Health, Health News, December, 1949.

ROENTGENOLOGY IN DIAGNOSIS OF TB

Through "mass survey" examinations and through those carried out in connection with other medical procedures, diagnostic roentgenology is of first importance in discovering those people in whom there are abnormalities in the thorax. It is probably the most efficient case-finding method in the diagnosis of pulmonary tuberculosis.

In many instances the roentgenologist is able to offer a reliable judgment as to whether a lesion thus discovered represents pulmonary tuberculosis so that laboratory examinations may be carried out in an effort to prove or disprove this impression. Finally, the roentgenologist may be able to give a valuable estimate regarding the probability of activity of a known tuberculous lesion.—Colin B. Holman, M. D., in Proceedings. Staff Meetings of the Mayo Clinic.

AGEING PROCESSES GRADUAL

It is not easy to define old age. The stooped posture, wrinkled skin, and halting, high pitched speech are not necessarily characteristic. It is important to recognize that people do not wear out all at once, but that one system may show the effects of age before any of the others begin to. In some cases, however, all the aging processes are so gradual, that when the patient finally seeks medical advice, senility is manifest at first glance.—Arthur Freedman, M. D., in North Carolina Med. J.

*Issued manthy by the Natianal Tuberculasis Assaciatian and furnished thraugh the caurtesy af The West Virginia Tuberculasis and Health Assaciatian.

The President's Page

After every annual meeting (and I have been attending them since I was licensed to practice in West Virginia), I always feel sorry for the new program committee because I wonder how a different kind of a successful program can be built for the following year. At such times, it always seems to me that the bottom of the barrel has been reached in talent available for such an affair.

So, when the next annual meeting comes along, and I find that the program and scientific sessions are really different, as well as most interesting and informative, and that the speakers bring messages which mean much to the members of our Association, I feel that the program committee has again "done the impossible."

This past year it has been my privilege to watch how this committee works, and the very least I can do is to thank those who spent so much time arranging such an interesting program for the meeting in 1950. The attendance at the scientific sessions and section and society meetings was unusually good, and I attribute the increase in attendance to the quality of the scientific program arranged by the committee in cooperation with section and society officers.

There is much to remember about the convention. The Weirton Male Chorus presented a program that pleased everybody, and comment was general that they are entertainers *par excellence* in this particular field. Tom Millsop, president of Weirton Steel, already knows how very deeply our members appreciate his company's fine contribution to the success of the meeting.

The friendly cooperation of the executive staff and personnel at the Greenbrier is something that we shall not soon forget, and, the delightful cocktail party sponsored by the Greenbrier Clinic was easily one of the highlights of the convention.

Frank Holroyd's election as President is good news to all of our members. We all know how very hard he has worked for the success of the present campaign against socialized medicine. Notwithstanding his many years of service to his county society and the State Medical Association, his career in administrative medicine is not ending, but merely starting. He has what it takes to make a good President. We all pledge to him an aggressive, effective organization to help him in any program he may offer for 1951. Good luck to the new President in his every endeavor.

C. E. Watkins

President.

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FRANK HOLROYD, PRESIDENT

Frank Holroyd's election as president of the West Virginia State Medical Association has resulted in expressions of approval from doctors all over West Virginia. Everybody agrees that he is a "natural" for this highest office in the gift of the Association, and he will be given one hundred per cent support when he assumes the presidency January 1, 1951.

By experience and training, Frank Holroyd meets all of the qualifications required of a president. Besides serving a term as president of the Mercer County Medical Society, he has been secretary of that active organization for nearly eleven years.

He has served two full terms as a member of the Council, and has held membership on several active Association committees. As an organizer, he is tops in any doctor's language, and it is agreed that he has made one of the best public relations chairmen in the United States, having served in this capacity in this state since January, 1949. The very fact that West Virginia stands second in the nation in the number of resolutions opposing compulsory health insurance adopted by state, district, and county organizations is proof enough that he is a real leader in medical public relations.

Frank J. Holroyd, M. D.

The American Medical Association, recognizing his worth as an organizer, has called upon him several times for service in connection with the work of its various bureaus, departments, and committees. For three years, he has served as state and area chairman of the Conference of County Society Officers. He has been a member of the executive committee of the Conference for the past two years.

The new president is not waiting until December to chose committee chairmen. Appointments are already being made, and we venture the prophecy that the program for 1951 will have been mapped out and approved before he takes office the first of the year.

Congratulations to Doctor Holroyd upon his election as president. He carries with him to this office the best wishes and goodwill of every member of the State Medical Association. Besides being eminently qualified for the office, he is most deserving of the great honor that was bestowed upon him at the annual meeting at White Sulphur Springs.

A BIG PROGRAM

Agendas that included about every topic that could possibly be discussed by doctors were cleared by the Fact Finding and Legislative Committee, the Council, and the House of Delegates during the month of July.

Outstanding among the recommendations agreed to by these three groups are the following:

First: The creation of a four-year school of medicine and dentistry in West Virginia, and the establishment of a medical education fund for capital expenditures and maintenance from surplus, present revenues, or reallocations of taxes as may be found necessary by the Legislature.

Second: Request to the State Department of Health that an investigation be made to ascertain whether or not in the future osteopathic physicians should be required to meet the same qualifications and take the same examinations required of doctors of medicine in this state.

Third: Recommendation that a licensing board be created for the purpose of examining practical nurses for license in West Virginia.

Fourth: That the present unsatisfactory coroner's system be abolished and that medical examiners be appointed in each county with the power to order an autopsy.

This is a big program, and one worthy of support by all forward-thinking people of West Virginia. If the program develops to the extent where it is offered as the legislative program of the West Virgina State Medical Association for 1951, it will no doubt receive the united support not only of all of the members of the State Medical Association, but members generally of allied groups.

BUREAUCRATIC EFFRONTERY

The House Lobbying Committee, searching for evidence of illegal activities, recently questioned Mr. Oscar Ewing, Federal Security Administrator, for three hours relative to some of his activities which would appear to tend toward propaganda.

The Committee asked for a complete statement on cost to the government of any speeches by Mr. Ewing or others in FSA designed to promote national health insurance. This is to include cost of preparing speeches and travel expense. The Committee also instructed its staff to obtain an accounting of money collected and spent for the 1948 National Health Assembly in Washington, which Representative Clarence Brown (R.-Ohio) suggested had political motivation and had been arranged to promote national health insurance.

Mr. Ewing said he was doing everything he considered proper to push the Truman health plan. Of his speeches in its behalf, he said: "It is my conception that when we keep within the realm of public discussion it is perfectly proper." In this he was supported by the chairman, Representative Frank Buchanan (D.-Pa.), who quoted a General Accounting Office spokesman as saying officials of Mr. Ewing's rank may engage in politics, although these activities would be illegal for Mr. Ewing's employees.

Mr. Ewing was questioned closely about two meetings. At the first, he admitted advising a group of organizations on strategy to win Senators over to Reorganization Plan 27, which was subsequently defeated in the House. The second meeting was a luncheon for representatives of veterans' organizations, given in the FSA building with Mr. Ewing as host. There he urged support for Plan 27, but he said most discussion was on the United Medical Administration bill. He said he paid for the food served, but that FSA messengers were used as waiters.

Mr. Ewing also said that he had given 33 speeches this year, "but if there's a sentence of politics in them I pay my own way." He explained that FSA has "lots of information to disseminate" and hires 64 public relations people, but that "they don't spend much time in speech writing." He replied to criticism of his European trip by saying "Why, without question it was an official mission." The hearing was not completed and more information was asked for.

It would seem to the casual observer that at least some bureaucrats on the Potomac certainly stoop to questionable ethics in their efforts to perpetuate themselves in power and to effect legislation which would translate into law their own ideas and desires. Moreover, the question of legality certainly comes to mind in some of these activities. What in the world does the FSA need with 64 public relations employees? Why should a governmental agency need or employ any public relations staff? No wonder the Federal Government requires deficit financing.

When we consider some of the activities in Washington we are nauseated by bureaucratic effrontery, and cannot help exclaiming with Cicero: O tempora! O mores!

S. O. S. ANSWERED

The request for copies of the July, 1950, issue of the West Virginia Medical Journal, printed in the August issue, resulted in a sufficient number of copies being sent to the headquarters offices in Charleston to meet current needs.

Although two hundred extra copies of the Convention Number were printed, the demand for the issue was unprecedented and resulted in a shortage of copies needed for the permanent files. Thanks to members for responding to this urgent appeal.

EMERGENCY MEDICAL PROCUREMENT

The A. M. A. Council on Emergency Medical Service recently held a two-day meeting in Washington at which representatives of the Army, Navy, and Air Force Medical Services were heard as to the medical needs of the armed services.

At this meeting, the Council:

1. Declared that more doctors are needed in the armed services, and that the initial needs must be supplied by "men who were permitted to pursue their medical education and otherwise deferred during World War II," principally former members of the Army's A.S.T.P. and Navy's V-12. Military officials made it plain that present demands could be met by men from these groups who were educated at government expense but have not served on active duty. Regarding these men, Dr. Elmer L. Henderson, A. M. A. president, declared: "The American Medical Association is determined that the men in the Armed Services will have adequate medical care even if legislation should prove necessary to insure this."

2. Discussed the possibility of legislation making it legally possible to call up this group of men without their consent.

3. Agreed to further publicize the bonus pay provision for medical volunteers. Under this law, medical officers who volunteer receive an additional $100 per month; this is not allowed if the men are called up on mandatory orders. Volunteers also retain their "separation rank."

On August 2, Representative Saylor (R.-Pa.) introduced H. R. 9311 which would amend the Selective Service Act by authorizing the President to require special registration and make draft calls on persons in needed professional, technical, and specialist categories who have not reached the age of forty-five. Such inductions, however, would not exceed twenty-one months in the armed forces. In making calls for such persons the President would induct in the following order of priority:

"First. Those who participated as students in the Army specialized training program or similar programs administered by the Navy, and persons who were deferred for service during World War II for the purpose of pursuing a course of instruction leading to education in one of the above categories, and who have had no active duty as commissioned officers.

"Second. Those who participated in the Army specialized training program or similar programs administered by the Navy and who have served on active duty as commissioned officers for less than twenty-one months (exclusive of the time spent in postgraduate training).

"Third. Those who had had less than ninety days' prior active honorable military or naval duty.

"Fourth. Those whose total active honorable military or naval duty is less than twenty-one months.

"Fifth. Others as prescribed by the President: Provided, that persons who are registered under this act and who are not commissioned in any of the services and are otherwise eligible and qualified for commission, who apply for a commission in either the Army or Navy may be deferred from induction for a period of sixty days to allow for processing and acceptance of such commission."

At this writing the world outlook is gloomy; Americans are dying on the battlefields of Korea; the shadow of World War III lowers ominously. A modern army must have the best medical service, else it cannot function effectively in combat. The American doctors have always responded and they will do so now.

POLITICAL ASPECT OF PILES

The recent event wherein a leader of the British Labor Party had a hemorrhoidectomy by the doctor of his choice,—outside of the Socialized Medicine program foisted upon Great Britain by the Labor Party, has provoked wide comment. The fact that this man elected to pay for a service he could have had for "free" shows how strong the desire to obtain the services of the doctor of one's choice can be. It can be assumed that this man was aware, at least as a politician, that there would perhaps be some comment on his act, but they were his piles, and he was in a position to exercise his rights. His act shows how strong the desire for free choice can be; it also demonstrates the shoddy standards of all Statism advocates.

The Labor Party insists, to the point of indirect compulsion, that only a few may have this right of choice of physician. And with all the insolence of Commodore Vanderbilt echo his: "The public be damned!" The Labor Party obtained Socialized Medicine for England as a marvelous, modern and progressive action that would benefit all . . . and more such arrant nonsense. Yet when a prominent leader of this party was harassed by piles he repudiated this foolish philosophy. Now if more politicians could be visited with this condition there mght be some hope for the future of the world.—Ralph A. Johnson, M. D., in Detroit Medical News.

MEDICINE'S PRIMARY OBJECTIVE

To provide better medical care for the people is, and always has been, medicine's primary objective. To have brought to the American people the finest medical care in the world is a tribute to the profession's adherence to its goal.—J. Kentucky St. Med. Assn.

" 'Tis not the dying for a faith that's so hard; 'tis the living up to it that is difficult."—Thackeray.

GENERAL NEWS

DR. FRANK J. HOLROYD, OF PRINCETON, NAMED PRESIDENT AT WHITE SULPHUR

Dr. Frank J. Holroyd, of Princeton, was elected President of the West Virginia State Medical Association at the 83rd annual meeting at The Greenbrier, in White Sulphur Springs, July 27-29, 1950. He will assume his new duties January 1, 1951, succeeding Dr. Charles E. Watkins, of Oak Hill.

Dr. A. R. Sidell, of Williamstown, who is completing two terms as a member of the Council, was elected first vice president, and Dr. Jacob C. Huffman, of Buckhannon, was reelected for his third consecutive term as second vice president.

Dr. T. Maxfield Barber, of Charleston, was reelected treasurer for his 24th consecutive term.

Doctor Holroyd was born at Athens, April 8, 1907; son of Mrs. Hattie Shumate Holroyd and the late Dr. Fred F. Holroyd, of Princeton; A. B., Concord College, 1925; B. S., West Virginia University, 1927; M. D., University of Maryland School of Medicine, 1929. He interned at the U. S. Marine Hospital in Baltimore, 1929-30. He was licensed in West Virginia in 1929, and located at Princeton, where he is still engaged in the practice of his specialty of internal medicine.

He had post graduate work in internal medicine and cardiology at New York Post Graduate Hospital, Harvard University Hospital, Boston, and Barnes Hospital, St. Louis.

Doctor Holroyd is a past president of the Mercer County Medical Society and has served as its secretary since January 1, 1940. He served as a member of the Council of the West Virginia State Medical Association for two consecutive terms. He was elected a Fellow of the American College of Physicians in 1939.

He was named public relations chairman of the State Medical Association in January, 1949, and is still serving in that capacity. For the past three years he has been state and area chairman of the National Conference ("Grass Roots") of County Medical Society Officers, and is also a member of the executive board of the conference.

AMA Delegates and Alternates

Dr. Walter E. Vest, of Huntington, was reelected AMA delegate. Dr. Pat A. Tuckwiller, of Charleston, was elected AMA alternate to succeed Dr. W. P. Black, of that city.

Doctor Vest has served as AMA delegate from West Virginia since 1934. Previously he had served two terms as AMA alternate. Dr. George F. Evans, of Clarksburg, is the hold-over AMA delegate from this state, and Dr. James L. Wade, of Parkersburg, holds over for another year as alternate.

CHASE-GREENBRIER PHOTO
WHITE SULPHUR SPRINGS

At the Annual Banquet at the Greenbrier, Saturday evening, July 29, 1950: Frank J. Holroyd, M. D., Princeton, President Elect; Mrs. Charles E. Watkins, Oak Hill; Mrs. Holroyd; and Charles E. Watkins, M. D., President.

Maternal and Child Welfare

All of the present members of the committees on Child Welfare and Maternal Welfare were reelected. New chairman of each committee will be named by Doctor Holroyd, the president elect.

Councillors

Four members of the Council were reelected for a two year term as follows:

First district, Dr. L. Rush Lambert, Fairmont; third, Dr. George F. Evans, Clarksburg; fifth, Dr. E. Lyle Gage, Bluefield; and sixth, Dr. Russel Kessel, Charleston.

Dr. Hu C. Myers, Philippi, was elected councillor from the second district to succeed Dr. M. H. Porterfield, of Martinsburg, and Dr. Athey R. Lutz, Parkersburg, was named councillor from the fourth district to succeed Dr. A. R. Sidell, of Williamstown.

Doctor Porterfield and Doctor Sidell, who are each completing two consecutive terms as members of the Council, were not eligible for reelection. Doctor Porterfield is at present on active duty with the Medical Corps of the Navy, in Philadelphia. Doctor Sidell will continue as a member of the Council by virtue of his election as first vice president.

1951 MEETING AT THE GREENBRIER

The 84th annual meeting of the West Virginia State Medical Association will be held at The Greenbrier, White Sulphur Springs July 19-21, 1951.

DOCTOR WATKINS RECEIVES EMBLEM

Immediately following the presidential address at the 83rd annual meeting of the West Virginia State Medical Association, July 28, Dr. Charles E. Watkins was presented with the President's Emblem. The presentation was made by Dr. Thomas G. Reed, chairman of the Council. This gold charm is presented annually to the President in recognition of his services to organized medicine in West Virginia.

DR. DON ROBERTS HEADS GP ACADEMY

Dr. Donald R. Roberts, of Elkins, was elected president of the West Virginia Academy of General Practice at a meeting held in White Sulphur Springs during the 83rd annual convention of the West Virginia State Medical Association. He succeeds Dr. James L. Patterson, of Logan.

Dr. Victor Politano, of Milton, was named vice president of the Academy, and Dr. Carl B. Hall, of Charleston, was reelected secretary.

Dr. T. Maxfield Barber, of Charleston, was named chairman of the board of directors; Drs. James L. Patterson, of Logan, and Thomas B. Blake, of St. Albans, delegates to the American Academy of General Practice; and Dr. Myer Bogarad, of Weirton, and Dr. Halvard Wanger, of Shepherdstown, alternates.

HOUSE OF DELEGATES ADVOCATES SPECIAL FUND FOR FOUR-YEAR SCHOOL

The first session of the House of Delegates of the West Virginia State Medical Association was convened at The Greenbrier in White Sulphur Springs Thursday afternoon, July 27, with Dr. Charles E. Watkins, the president, in the chair. The second session was held Friday afternoon.

Besides the elected officers and past presidents, the House is composed of 86 delegates. Of this number, 53 were present at the opening session, and 68 at the second session.

FIRST SESSION, JULY 27

At the first session on Thursday afternoon, Dr. Frank J. Holroyd, chairman of the public relations committee, submitted a report concerning replies received from 19 of the 25 candidates for Congress in this state. He reported that 18 of the 19 candidates who replied to an inquiry concerning their stand on socialized medicine or compulsory health insurance stated that they were opposed to such legislation.

The chairmen of several committees submitted annual reports, which are printed elsewhere in this issue of The Journal.

Recommendations Approved

The recommendations made in the report submitted by Dr. D. A. MacGregor with reference to the appointment of coroners, the expansion of the DPA advisory board to include a pediatrician and a psychiatrist, the disposition of the matter of the creation of a composite medical licensing board, and the creation of a licensing board for practical nurses were unanimously approved.

Four-Year School

Doctor MacGregor reported that his committee had gone on record unanimously as recommending that the West Virginia State Medical Association reaffirm its stand in favor of the creation of a four-year school of medicine and dentistry in West Virginia.

Medical Education Fund Advocated

Following the reading of this part of the report, Dr. Thomas G. Reed, chairman of the Council, reported the adoption by the unanimous vote of the Council of the following resolution offered by Dr. E. Lyle Gage, Councillor from the sixth district, at the pre-convention meeting held July 26:

> "Whereas, The West Virginia State Medical Association has for the past several years urged and recommended that a four-year school of medicine and dentistry be established within West Virginia in order to better serve the health needs of our citizens; and,
>
> "Whereas, The facts that have been established and the recommendations on medical education that have been made by our Association as to the needs, location, and costs have been confirmed by the independent surveys that have been made this year by the experts that were selected by the Legislature's Interim Committee, Drs. Herman G. Weiskotten, of Syracuse University, and Wilburt C. Davison, of Duke University:

"Now, Therefore, Be It Resolved: That the West Virginia State Medical Association again urge and recommend that the Legislature of West Virginia establish a four-year school of medicine and dentistry within West Virginia at the next regular session of the Legislature in 1951, and that a special fund be set up to be known as the "Medical Education Fund" for capital expenditures and maintenance from surplus, present revenues, or by the reallocation of taxes as found necessary by the Legsilature, and that copies of this resolution be forwarded to the press, the Governor, the President of the Senate, the Speaker of the House, the members of the Interim Committee and each member of the Legislature of the State of West Virginia."

The resolution adopted by the Council was then unanimously approved by the House of Delegates.

Special Assessment in 1951

Doctor Reed reported that the Council had recommended a special assessment of $5.00 against each member for 1951 to help pay current expenses and defray expenses of the 1951 convention. A motion to accept the recommendation of the Council was amended to provide for a special assessment of $10.00 against each member in 1951, and the amended motion was unanimously adopted.

Recommendations made in reports submitted by the UMW Advisory Board, and the Committee on Hospital Relations were also unanimously approved.

Resolutions Adopted

Several resolutions were introduced, and all but one were held over for one day. The resolution offered by Dr. Sobisca S. Hall concerning the ASTP and V-12 training program was taken up for immediate consideration and unanimously adopted at the first session of the House of Delegates.

All resolutions adopted by the House are printed in full elsewhere in this issue of The Journal.

SECOND SESSION, JULY 28

Two amendments to the Constitution were offered by Dr. Sobisca S. Hall for the Committee on Revision of Constitution and By-Laws.

Amendments to Constitution

The first would limit membership in the West Virginia State Medical Association to doctors of medicine licensed to practice in West Virginia, and the second would increase the annual dues of members from $15 to $25.

Both amendments will lie over for one year and will be acted upon at the annual meeting in White Sulphur July 19-21, 1951.

By-Laws Amended

Doctor Hall also offered for his committee several amendments to the By-Laws, and all were adopted at the second session of the House of Delegates.

One amendment creates a Grievance Committee, composed of the five immediate past presidents. This committee is empowered to hear complaints made by laymen, but the Council will continue as the Board of Censors of the Association to consider questions involving the right and standing of members.

Another amendment clarifies the matter of succession in the office of president, particularly in the event of the death of the president elect or his incapacity to qualify.

Two other amendments to the By-Laws limiting membership to doctors of medicine licensed to practice in West Virginia will not be acted upon until the amendment to the Constitution on the same subject is disposed of at the next annual meeting.

Dr. Sobisca S. Hall offered an amendment to the By-Laws authorizing the president to appoint a Parliamentarian. On his motion, the amendment was taken up for immediate consideration and adopted.

Constitutional Amendment Rejected

The proposed amendment to the Constitution limiting past presidents to membership in the House of Delegates for three years following their tenure of office was rejected, having failed to muster a two-thirds majority of the delegates present and voting.

Resolutions of Thanks

Just before the close of the second session the House unanimously adopted the following resolutions of thanks:

By Dr. Raymond A. Updike, Montgomery: Expressing thanks to the members of the Program Committee for their untiring efforts in affording an excellent program for this meeting.

By Dr. I. I. Hirschman, Huntington: Thanking the management of the Greenbrier Hotel for the efforts of the personnel generally to afford the best in hospitality for those attending the convention.

By Dr. W. Fred Richmond, Beckley: Thanking The Greenbrier Clinic and its director, Dr. James P. Baker, for sponsoring a cocktail party immediately preceding the annual banquet.

By Dr. Walter E. Vest, Huntington: Thanking the Associated Press, the United Press and the newspapers of the state for the complete news coverage provided during the annual meeting.

1951 Annual Meeting

The House voted unanimously to return to The Greenbrier for the 84th annual meeting in 1951. The convention will be held Thursday, Friday, and Saturday, July 19-20-21.

WOMAN'S AUXILIARY ADVISORY COMMITTEE

Dr. Frank J. Holroyd, of Princeton, president elect of the State Medical Association, has appointed the following doctors as members of the Woman's Auxiliary Advisory Committee to serve until the next annual meeting at White Sulphur Springs, July 19-21, 1951:

Charles L. Goodhand, Parkersburg, chairman; Robert J. Reed, Jr., Wheeling; Ross P. Daniel, Beckley; S. Elizabeth McFetridge, Shepherdstown; and William A. Thornhill, Jr., Charleston.

COUNCIL CLEARS RECORD AGENDA AT SUMMER MEETING AT WHITE SULPHUR

The pre-convention meeting of the Council held at The Greenbrier in White Sulphur Springs, July 26, 1950, proved to be one of the most lengthy sessions in recent years. The meeting was called to order at four o'clock and the night session which convened immediately after dinner was served was not adjourned until nearly midnight.

All members of the Council were present with the exception of Dr. M. H. Porterfield, of Martinsburg, who is on active duty with the Medical Corps of the Navy, being stationed at Philadelphia.

Several routine matters were discussed and acted upon, and a great deal of time was consumed in the consideration of the report submitted for the Fact Finding and Legislative Committee by Dr. D. A. MacGregor, the chairman.

Composite Licensing Board

Several members of the Council participated in the discussion of that part of Doctor MacGregor's report which concerned the proposed creation of a composite medical licensing board. Doctor MacGregor stated that the West Virginia Osteopathic Society had declined to join in the program to try to obtain the passage of this type of legislation at the 1951 session of the legislature, and the advisability of seeking a change in the law was also discussed.

The Council voted unanimously to direct Dr. Walter E. Vest and Dr. James S. Klumpp, of Huntington, members of a sub-committee of the Fact Finding and Legislative Committee, to present to the State Board of Health a request that an investigation be made to ascertain whether or not in the future osteopathic physicians should be required to meet the same qualifications and to take the same examinations required of doctors of medicine before being licensed to practice in West Virginia.

The Council also accepted the recommendation of the committee that the sub-committee continue active and that the members be authorized to hold further meetings with representatives of the West Virginia Osteopathic Society if they deem such meetings necessary and proper.

Exponded Orthopedic Boord Approved

The Council also accepted the recommendation of the Fact Finding and Legislative Committee that the orthopedic advisory board be enlarged to include a pediatrician and a psychiatrist.

Record Number of Honorory Members Elected

The following doctors were elected to honorary lifetime membership:

Waitman Willey Orr, Rachel
Carroll Augustus Davis, Logan
Harold Douglas Gunning, Ronceverte
Lawrence Arthur Jarrett, Dunbar
Ernest Fred Gott, Charleston
Morgan Thornton Morrison, Sutton
Ralph Greely Cutright, Buckhannon
Ross M. Dodson, Huntington
Robert Waldorf Fisher, Morgantown
William Hay McLain, Wheeling
Okey Maxwell Staats, Wheeling
Michael Gaydosh, Wheeling
Charles Hutchinson Keesor, Wheeling

This was the largest group of doctors ever elected to honorary membership at any single meeting of the Council.

AMA Associate Fellowship

Dr. William Andrew McMillan, Charleston; Dr. Benjamin Franklin Brugh, Clearwater, Florida; and Dr. Robert Armstrong Ashworth, Moundsville, were nominated for election to Associate Fellowship in the AMA. Doctor Brugh was formerly located at Montgomery.

Publicotion Committee Reports

Dr. Walter E. Vest, chairman of the Publication Committee, submitted his annual report in which it was disclosed that there has been no decrease in Journal advertising during the past eighteen months. On the contrary, a slight increase has been noted, and the advertising receipts are now sufficient to pay for the publication and distribution of the Journal.

Doctor Van Liere Reelected

Dr. E. J. Van Liere, of Morgantown, whose term as a member of the Publication Committee expires December 31, 1950, was unanimously reelected as a member of that committee. He will hold office until December 31, 1955.

Code of Autopsy Procedures Approved

Doctor Kessel, discussing that part of the report of the Fact Finding and Legislative Committee which related to coroners and autopsy procedures, reported that a standard Code of Autopsy Procedures has already been approved by representatives of the Assotion of Pathologists of West Virginia, as well as by the West Virginia Funeral Directors Association. The Code was accepted with the proviso that a member of the Council be named on the committee.

Chonge in Coroner System

Doctor Kessel further discussed the reported need for changes in the coroner system in West Virginia by the enactment of new or additional legislation which would be based upon laws now in effect in Maryland and Virginia. The proposed legislation would provide for the abolition of the coroner system and the substitution therefor of medical examiners. There would be a full-time chief medical examiner, selected upon the advice of the medical licensing board.

In addition, a licensed physician in each county would be appointed as medical examiner and he would be empowered to order an autopsy.

The state would be divided into districts so as to provide at least one capable pathologist to handle the work in that district.

A state laboratory would be established, probably as a part of the State Hygienic Laboratory, which would be adequately prepared to handle problems

in toxicology and the expert identification of hair, blood stains, etc.

Doctor Kessel was continued as Council representative in the work of the committee looking toward a change in the law affecting coroners. He is to serve with Dr. M. L. Hobbs, of Morgantown, and Dr. W. G. J. Putschar, of Charleston.

Licensing Board for Practical Nurses

The Council also considered the recommendation of the Fact Finding and Legislative Committee that a separate licensing board be created for the purpose of examining practical nurses for licensure in West Virginia.

The recommendation was unanimously approved with the understanding that the proposed law would provide that the board be composed of two doctors of medicine, three practical nurses, and two registered nurses, all under the supervision of the State Board of Health.

Four-Year School

The Council again went on record as approving the creation of a four-year school of medicine and dentistry in West Virginia, and a resolution covering the matter was unanimously adopted. The chairman, Dr. Thomas G. Reed, was directed to present the resolution to the House of Delegates at the first session the following afternoon. (The resolution is included as part of a news story covering sessions of the House of Delegates, found elsewhere in this issue of the Journal).

Emergency Medical Service Report

The following recommendations, submitted by Dr. Russel Kessel, chairman of the Committee on Emergency Medical Service, in his annual report to the House of Delegates, were unanimously approved by the Council:

1. The West Virginia State Medical Association is to sponsor two one-day meetings, with Dr. J. J. Lawless, of Morgantown, as the speaker. Doctor Lawless has recently attended the course at Western Reserve University on atomic energy.

2. The meetings are to be held, respectively, at Clarksburg and Charleston, and each component society is to be requested to send members to the meeting in the ratio of one to fifty, or percentage thereof, of the entire membership.

3. The information received from Doctor Lawless by the designated physicians is to be used by them in instructing members of their own component societies in the care of casualties from atomic warfare.

4. The State Health Department is to be requested to send representatives to the meeting and to request that all county health officers be present. All industries in West Virginia which have a full-time medical department are to be invited to participate in the meetings.

5. The recommendation is to be made to Dr. C. E. Watkins, the president, that Dr. Thomas G. Reed, of Charleston, be named as chairman of the Committee on Emergency Medical Service to succeed Doctor Kessel, who is a member of the Medical Corps of the United States Naval Reserve, and who, for this reason, feels that he should not continue as chairman.

Junior Academy of Science Award

The Council for the second consecutive year authorized an award of $10.00 for the best paper submitted on a medical subject in 1951 by a member of the Junior Academy of Science in this state.

Renewal of VA Contract Approved

The action of the Council in voting by a poll of the members to renew the contract with the Veterans Administration for the fiscal year ending June 30, 1951, was ratified.

Unification of Service Plans

The chairman was authorized to appoint three members of the Council to study the advisability and feasibility of ultimate unification in the administration of the Varous Blue Cross and Blue Shield organizations in West Virginia. The committee was authorized to confer with representatives of medical care plans in the study of this problem.

TENNIS TOURNAMENT RESULTS

Dr. P. A. Tuckwiller and Dr. S. L. Bivens, both of Charleston, were the winners of the doubles championship at the tennis tournament held in connection with the 83rd annual meeting of the West Virginia State Medical Association, at the Greenbrier, July 27-29.

The finals of the singles matches could not be played during the meeting, as there was not sufficient time left for this event on Saturday afternoon, July 29. Doctor Bivens and Dr. Robert M. Biddle, of Parkersburg, will play for the singles championship some time late in August on courts to be mutually agreed upon. The winner will be awarded the championship trophy offered by Kloman Instrument Company, of Charleston.

The tennis tournament committee was composed of Dr. S. L. Bivens, of Charleston, chairman, Dr. John E. Lutz, also of Charleston, and Dr. Robert M. Biddle, of Parkersburg.

PROGRAM COMMITTEE FOR 1951

The first official act of Dr. Frank J. Holroyd, of Princeton, as president elect of the West Virginia State Medical Association, was to appoint a program committee which will arrange the scientific program for the 84th annual meetng at White Sulphur Springs, July 19-21, 1951.

Dr. Lawrence J. Pace, of Princeton, will serve as chairman of the committee, and the other members are Drs. Cecil O. Post, of Clarksburg, and James L. Wade, of Parkersburg.

The first meeting is being held at Charleston August 20, and the committee will at that time decide upon the type of program to be presented in 1951.

WEIRTON STEEL MALE CHORUS WINS PLAUDITS AT WHITE SULPHUR BANQUET

The banquet at White Sulphur on Saturday evening, July 29, was one of the most colorful ever held in connection with an annual meeting. It came as a fitting climax to a most interesting three-day session, which marked the appearance of nationally known speakers who discussed varied topics of interest to the members of the Association and guests present from other states.

The Weirton Steel Male Chorus, under the direction of T. Herbert Davies, proved to be one of the finest musical organizations ever heard in this state. The program that was presented, with Gerald Ferguson, accompanist, included classical, semi-classical and popular selections, and the audience composed of nearly four hundred doctors, members of the Auxiliary, and guests, demanded and received many encores.

The banquet was moved from the auditorium to the Colonnades Dining Room at The Grenbrier, and extra tables had to be set in the wide corridors and the annex which adjoins the dining room.

Director Davies is dynamic in appearance, possesses a most pleasing personality, and is undoubtedly one of the best leaders of male choruses in the country. He has molded together an organization that reflects great credit upon the Weirton Steel Company. It was through the courtesy of the company, and its president, Mr. Thomas E. Milsop, that the chorus appeared at The Greenbrier.

There could not possibly be a better type of public relations than the appearance of this singing chorus before groups in and outside of West Virginia. Newspapers published in cities where the chorus has made appearances have been loud in their praise of the group. The fact that the chorus has been invited to appear on the NBC network attests to its popularity among listeners on the airwaves.

Mr. Ray M. Coryll, director of public relations for the Weirton Steel Company, proved to be a most charming and efficient master of ceremonies. His running comments during the progress of the program added a live touch that kept everybody in a good humor.

AUXILIARY GOLF RESULTS

Mrs. Russel Kessel, of Charleston, won the award for low net at the annual Auxiliary Golf Tournament at White Sulphur Springs, July 27-29. Other awards were made as follows:

Low gross, Mrs. John F. McCuskey, Clarksburg; blind bogey, Mrs. R. R. Summers, Charleston; second low net, Mrs. E. B. Tucker, Morgantown; second low gross, Mrs. B. F. Puckett, Oak Hill; most fives, Mrs. Dana T. Moore, Parkersburg; high gross, Mrs. William R. Yeager, Parkersburg; and most eights, Mrs. Fred J. Potter, Parkersburg.

CHASE-GREENBRIER PHOTO
WHITE SULPHUR SPRINGS

Weirton Steel Male Chorus at the Annual Banquet, Saturday, July 29.

MRS. ROSS P. DANIEL INSTALLED AS PRESIDENT OF WOMAN'S AUXILIARY

Mrs. Ross P. Daniel, of Beckley, was installed by Mrs. A. A. Herold, president of the Woman's Auxiliary to the American Medical Association, as president of the Woman's Auxiliary to the West Virginia State Medical Assocation, at the 26th annual meeting at White Sulphur Springs, July 29, 1950. She will hold office until the next annual meeting at the Grenbrier, July 19-21, 1951.

Mrs. Ross P. Daniel

Mrs. John F. McCuskey, of Clarksburg, was named president elect, and vice presidents were elected as follows: First, Mrs. Lynwood D. Zinn, Clarksburg; second, Mrs. W. A. Thornhill, Jr., Charleston; third, Mrs. Frank J. Holroyd, Princeton; and fourth, Mrs. Gates Wayburn, Huntington.

Mrs. Seigle W. Parks, of Fairmont, was elected recording secretary, Mrs. L. M. Halloran, of Beckley, corresponding secretary, and Mrs. Charles L. Goodhand, of Parkersburg, treasurer.

Mrs. Daniel, daughter of Mr. and Mrs. Charles H. Bonnesen, was born at Grafton, but moved to Wheeling when quite young. She received her early education in the public schools of that city. She is an alumnus of West Virginia University, where she was affiliated with Chi Omega sorority. She was active in dramatics at Wheeling High School and the University, and is a charter member of the Beckley Little Theater group.

She was married June 22, 1922, to Ross Preston Daniel, and they lived in Memphis until Doctor Daniel received his M. D. degree from the University of Tennessee College of Medicine.

She served as president of the Beckley Woman's Club 1933-34, and is now chairman of the Youth Conservation Committee. She was the first campaign chairman of the Community Concert Association, and is now a member of the Board of Directors. She also holds membership in the Monday Music Club, the American Legion Auxiliary, and the Pan Hellenic Association. She has served as president of the West Virginia Alumni of Beckley, and West Virginians Incorporated, and is president of the Captain James Allen Chapter, Daughters of the American Revolution.

Mrs. Daniel is past president of the Woman's Auxiliary to the Raleigh County Medical Society. She has also served as first and third vice president and treasurer of the Woman's Auxiliary to the West Virginia State Medical Association. She was a member of the resolutions committee of the Woman's Auxiliary to the AMA at the San Francisco convention in June, 1950. She was named president elect of the West Virginia Auxiliary at the annual meeting at White Sulphur Springs in 1949.

President Herold Guest Speaker

Mrs. Arthur A. Herold, of Shreveport, Louisiana, President of the Woman's Auxiliary to the American Medical Association, was the guest speaker at the annual luncheon held at the Casino Saturday afternoon, July 29. Mrs. Herold is well-known to many members of the West Virginia Auxiliary, and her advice and guidance will be invaluable in the Auxiliary work that lies ahead.

The following are excerpts from Mrs. Herold's address before the Auxiliary:

"I am happy to be with you today and I am enjoying my visit so much that it gives me a feeling of confidence in visiting other State auxiliaries. This is my first state visit since I became president and I only hope that the other meetings will be as pleasant as yours has been.

"The first important step is to have good fellowship among your members and to be informed about auxiliary aims and projects. Know your local, state and National Auxiliaries and keep closely in touch with those who are your leaders. There must also be unity of aim and purpose between the Auxiliary and the Medical Society. The Auxiliary must not say one thing and the Medical Society another.

"The urgent public relations program on which we have been working with the National Committee has shown that where there is perfect cooperation between the auxiliary and the Medical Society the work has been better and more thoroughly accomplished. I should like to mention here the four major activities which were given us as our responsibility:

1. An effective endorsement drive among women's organizations. Your organization has been outstanding in this phase of the work and I congratulate you.
2. Participation in the work of the Medical Society Speaker's Bureau.

3. A well organized literature distribution system.

4. Newsworthy publicity to women's page editors.

"There should not be a doctor in this country who does not register and vote this year and there should not be any member of a doctor's family who fails in these basic responsibilities. Every Auxiliary should begin now to check it files and see that all are registered and all are voting. Also offer your services to your respective medical societies. If the League of Women Voters puts on a campaign, work with them. Let them know that we want to present the facts to the American people and then leave it to them to cast their vote as they think best. We must learn to work with other organizations, for I think in this respect our auxiliary public relations needs to be greatly improved.

"This concentration of effort on assisting in the work of our National Education Campaign has stimulated our members and has made them more interested in and conscious of the importance of our auxiliary. However, while stressing the significance of this program we have come to realize that political action should never be the sole concern of the wives of physicians. Of course, if we fail to stem the tide toward the "welfare state", there will be no need for any other type of program, but we must take the optimistic view and feel that we shall continue to need to build for the future as well as to continue our present fight.

"The only way to approach any public relations problem is with the determination that it can and must be solved. This is why I was so pleased when the A.M.A. suggested that we adopt its twelve-point program for the advancement of medicine and public health as a basis for our long range health education program. This program has long since passed the blueprint stage and is fast becoming a positive and active program. The implementation of this twelve-point program is of the utmost importance if the threat of political medicine is to be permanently dissolved.

"On the train coming here, I read a book written by Gerald Johnson, the title of which is 'Incredible Tale'. This book is well worth reading and I recommend it to you. In this book, the author said that Presidents come and go, dictators come and go, but the average American is always with us. It is this average American to whom we wish to carry our message.

"Alex Carrell has said 'The quality of life is more important than life itself', and if we carry the facts against the welfare state to the average American, we shall be helping our doctors in their determination to preserve for the American people the quality of life as well as life itself."

Standing Committees

The following chairmen of standing committees were named for the ensuing year:

Archives, Mrs. Herbert M. Beddow, Charleston; Exhibits, Mrs. Dana T. Moore, Parkersburg; Finance,

CHASE-GREENBRIER PHOTO
WHITE SULPHUR SPRINGS

At the Annual Banquet at the Greenbrier, Saturday evening, July 29, 1950: Mrs. Ross P. Daniel, Beckley, President Elect, Woman's Auxiliary to the West Virginia State Medical Association; Mrs. Arthur A. Herald, Shreveport, Louisiana, President of the Woman's Auxiliary to the American Medical Association; and Mrs. Dana T. Moore, Parkersburg, immediate past President of the West Virginia Auxiliary.

Mrs. H. E. Beard, Huntington; Historian, Mrs. Paul L. McCuskey, Parkersburg; Legislation, Mrs. Francis J. Gaydosh, Wheeling;

Necrology, Mrs. F. Carl Chandler, Bridgeport; Organization, Mrs. John F. McCuskey, Clarksburg; Parliamentarian, Mrs. U. G. McClure, Charleston; Program, Mrs. J. E. Spargo, Jr., Wheeling;

Publications (Editor of News Bulletin), Mrs. D. C. Ashton, Beckley; Circulation Manager, Mrs. R. G. Broaddus, Beckley; Press and Publicity, Mrs. D. D. Daniel, Beckley; Public Relations, Mrs. Ben W. Bird, Princeton; Revisions, Mrs. C. G. Power, Martinsburg; and Today's Health, Mrs. Paul P. Warden, Grafton.

Special Committees

Bulletin, Mrs. H. C. Hays, Williamson; Credits and Awards, Mrs. Newman Newhouse, Charleston; Nurse Recruitment, Mrs. H. S. Keister, Fairmont; Speaker's Bureau, Mrs. J. M. Coram, Beckley; Special Projects, Mrs. W. E. Hoffman, Charleston; and Southern Medical, Mrs. U. G. McClure, Charleston.

Registration

The registration of members totaled 151, which was slightly under the record attendance in 1949.

1951 Meeting

The 27th annual meeting of the Auxiliary will be held conjointly with the West Virginia State Medical Association at the Greenbrier in White Sulphur Springs, July 19-21, 1951.

HILLSDALE CANCER PREVENTION PLAN

The success of the Hillsdale County (Mich.) cancer-prevention plan is told by Clive Howard in his article "How to Prevent 100,000 Cancer Deaths a Year" in the September Woman's Home Companion.

Medical science has reached the point where it can save two patients out of every three afflicted with cancer, but the tragedy is that we are saving only one of the three and letting a hundred thousand people a year die needlessly, the article states.

The answer to this tragic problem, says the author, is the practical method adopted by Hillsdale County in 1947—every doctor's office a cancer-detection center. Hillsdale County has set an example which the whole nation should take to heart and which the whole nation could easily follow, the article states.

The plan, which was suggested by Dr. Norman Miller of the University of Michigan and chairman of the state's Cancer Control Committee, was put into effect only after it had been discovered that sixty-nine of Hillsdale's hundred and forty-six known cancer cases died within a year.

CALORIES AND THE DEATH RATE

One-half the peoples of this earth live on less than 2250 calories per day and the crude death rate among such people averaged, around 1930, thirty or more per 1000. Whereas only one-fifth of the peoples of this earth enjoyed average daily diet of 2875 calories, or more, their crude death rate in 1930 was as low as 12 per 1000.—J. F. in Ohio State Medical Journal.

ENTHUSIASTIC AUDIENCE GREETS CLEM WHITAKER AND LEON BAXTER

Clem Whitaker and Leone Baxter, of the firm of Whitaker & Baxter, which has charge of the National Education Campaign of the American Medical Association, were greeted by an enthusiastic audience that packed the auditorium upon their appearance at an open meeting at White Sulphur Springs, July 27, immediately preceding the first session of the House of Delegates.

This famous team of public relations experts apparently answered all questions that any doctor may have had concerning the conduct of the current campaign to defeat compulsory health insurance. The topics discussed were separated so that there was no repetition, but the two addresses were integrated so that there was continuity in the matters discussed. (Ed: The papers presented by the speakers will be published in the October issue of the West Virginia Medical Journal).

The whole program of the American Medical Association in favor of voluntary health insurance was discussed, and the speakers gave full credit to the doctors of America for wholehearted cooperation in their efforts to win approval of the program in Congress.

The overwhelming defeat in the House of Representatives of Reorganization Plan No. 27 was cited as a "straw in the wind." Neither speaker believes that any effort will be made by the Washington bureaucrats to bring the issue of socialized medicine to a vote during the present session of Congress.

Both speakers agreed with Dr. Elmer L. Henderson, President of the American Medical Association, that American medicine is trying to force the issue in Congress so that the matter of this virulent type of socialism might be settled for all time. The speakers were loud in their praise of the work done by the members of the public relations committee in West Virginia, as well as the effective work of members of county societies and the Auxiliary. A breakdown of the plan for the AMA National Advertising Campaign scheduled for October was given, and the statement was made that an advertisement would be carried in every newspaper in America during the week of October 8, 1950. In addition, the radio and national magazines will be used extensively in the campaign.

Both speakers were given a cordial reception, and a most attentive audience remained throughout the hour devoted to a discussion of the National Education Campaign.

TIME TO WAKE UP

Any large group of individuals—be they farmers, miners, veterans—unwittingly throw nooses around their own necks. They give way to the elements of a welfare state in the belief that they will gain. Actually everybody loses, including members of the groups whose votes are sought. They catch a bear and can't let it go and the men they sent to Congress tax-spend, tax-spend, tax-spend their country into insolvency. We hope America still has time to wake up and save itself..—Rocky Mt. Med. J.

GRIEVANCE COMMITTEE PROVIDED FOR IN AMENDMENTS TO BY-LAWS

The followng is a verbatim copy of amendments to the By-Laws offered by the Committee on Constitution and By-Laws and adopted by the House of Delegates at the second session at White Sulphur Springs, July 28, 1950:

Grievance Committee

Amend Chapter VIII, Sec. 1, to include as one of the standing committees a "Grievance Committee." The name of this committee would be inserted in the Section after "Fact Finding and Legislation Committee."

Amend Chapter VIII, Sec. 2, by inserting at the end of the Section the following:

"The Grievance Committee shall be composed of the five living immediate past presidents of the West Virginia State Medical Association, listed in the order of their service, with the first immediate past president heading the list, and the name of the fifth living immediate past president appearing last on the list. As a president completes his term of office he shall become a member of the committee, with his name heading the list, and the name of the fifth member serving thereon shall automatically be dropped, so that in the future all living past presidents will serve five years as a member of the committee."

Amend Chapter VIII, Sec. 4, by inserting a new paragraph (g) as follows:

"The Grievance Committee is empowered to hear complaints against members of the Association, which may be made by laymen. The committee is authorized to elect its own chairman and adopt such policies, rules and regulations as may be agreed upon by a majority of the members, except that complaints may be filed directly with the committee or submitted by the Board of Censors or similar committee of a component society when it is found that such complaints cannot be settled at the local level.

"Nothing herein shall be construed in such way as to curb the powers of the Council as the Board of Censors of the Association to consider questions involving the right and standing of members as outlined fully in Sec. 3 of Chap. VII of the By-Laws, and it is not the intention of this section to interfere in any way with the rights of a component society to judge the qualifications of its own members as set forth in Sec. 5 of Chap. IX.

"If the committee cannot adjudicate the differences between the individuals concerned in any complaint that may be made, it shall report its findings, in writing, with or without recommendation, to the component society of which the doctor complained against may be a member. A copy of such findings shall also be sent to the Councillors who represent the particular Councillor District, as well as to the Chairman of the Council."

Amend Chapter VIII, Sec. 4, by properly relettering present paragraphs (g) to (o), both inclusive.

Succession in Office

Amend Chapter VI, Sec. 2, to read as follows:

"The Vice Presidents shall assist the President in the discharge of his duties. In the event of the death, resignation, or removal of the President, or his incapacity to serve, the First Vice President shall succeed him in office. If for any reason the First Vice President cannnot serve, then the Second Vice President shall act in his stead.

"In the event of the death of the President Elect, or his incapacity to qualify, then the First Vice President Elect shall succeed to the office of President. If he for any reason cannot take office, then the Second Vice President Elect shall qualify in his stead."

The following amendment to the By-Laws, offered at the second sesion of the House of Delegates by Dr. Sobisca S. Hall, was unanimously adopted:

Amend Chapter VI, Sec. 1, by adding at the end of the section the following: "He shall appoint a Parlimentarian to serve during his term of office."

PROPOSED AMENDMENTS TO THE CONSTITUTION

The following amendments to the Constitution of the West Virginia State Medical Association offered by the Committee on Revision of Constitution and By-Laws at the annual meeting of the House of Delegates at White Sulphur Springs, July 27-29, 1950, will be submitted to the House for final action at the 84th annual meeting at White Sulphur Springs, July 19-21, 1951:

Article IV

Sec. 2. Amend the section to read as follows:

"MEMBERS. Membership in this Association shall be limited to doctors of medicine licensed to practice in West Virginia who are members of a component medical society of the West Virginia State Medical Association."

(This Section now reads as follows: "MEMBERS. The members of this Association shall be the members of the component county medical societies.")

Article XI

Sec. 1. Amend the section to read as follows:

"Funds shall be raised by an annual per capita assessment of dues against members of the Association. Dues in the amount of $25 per annum shall be paid by each such member in the manner provided by the By-Laws."

(This Section now reads as follows: "Funds shall be raised by an annual per capita assessment of dues against members of the Association. Dues in the amount of $15 shall be paid by each such member in the manner provided by the By-Laws.")

AMA FALL ADVERTISING CAMPAIGN DESCRIBED BY DR. E. L. HENDERSON

A last minute change had to be made in the program for the two evening meetings on July 27 and July 28. Dr. Elmer L. Henderson was the guest speaker at an open meeting on July 27, and the presidential address of Dr. Charles E. Watkins was given on Friday evening, July 28. Doctor Watkins' paper is printed in this issue of The Journal. Several hundred doctors, members of the Auxiliary, and guests were present for each evening meeting.

Doctor Henderson Reports for AMA

Doctor Henderson spoke immediately before and following the showing of a sound film depicting the various activities of the American Medical Association. It proved to be one of the most interesting pictures ever shown before a medical group in this state.

Doctor Henderson said that the fight of American medicine against compulsory health insurance has stimulated a great public crusade to protect all the basic freedoms of the American people and to stop the march of state socialism in this state.

He said that America's development as an aggressive, powerful force in public affairs has given new courage to other professions, businesses and industries which are threatened with socialization.

Notionol Orgonizotion Join in Fight

"More than 10,000 national, state and local organizations, with many millions of members," he said, "have rallied to medicine's cause during the past year and a half and have taken positive action against compulsory health insurance or any other form of socialized medicine. They have done so because we have succeeded in getting the plain facts in the case to them.

"We can be proud of that broadening front, because medicine has won the support of the greatest cross-section of civic groups and public organizations ever amassed on a controversial issue in the history of this country. And there is now a sharpened public awareness that medicine's battle for freedom affects not only doctors, but every American."

AMA Advertising Compoign

Doctor Henderson said that the medical profession is not only ready, but determined to bring the issue of compulsory versus voluntary health insurance to a definite decision. "The full power of American medicine's drive to a decision," he said, "will be turned on early in October with a nationwide advertising campaign that will utilize three principal media, newspapers, radio, and magazines.

Patient: "Doctor, if there's anything wrong with me, don't frighten me half to death by giving it a long scientific name. Just tell me in plain English what it is."

Doctor: "Well, sir, to be frank, you're just plain lazy."

Patient: "Thank you. Now will you give me the scientific name for it so I can tell them at home?"—Bull. Columbus Acad. Med.

DR. JAMES L. PATTERSON REELECTED MCV PRESIDENT AT ANNUAL MEETING

Dr. James L. Patterson, of Logan, was reelected president of the West Virginia Chapter of the Medical College of Virginia Alumni Association at a meeting held in connection with the 83rd annual meeting of the West Virginia State Medical Association, at White Sulphur Springs, Thursday night, July 27, 1950.

Dr. Carl B. Hall, of Charleston, was named vice president, Dr. Herbert M. Beddow, of Charleston, secretary, and Dr. John H. Murphy, of Wheeling, treasurer.

Dr. Donald S. Daniel, of Richmond, president of MCV Alumni Association, and Dr. Charles M. Caravati, member of the MCV faculty, were guest speakers at the banquet immediately preceding the business session.

Doctor Daniel discussed the expanded program and facilities of the Medical College of Virginia, the benefits enjoyed by students from West Virginia, the current building and expanded curricular program of the College, and long range plans for housing units for students.

The members of the West Virginia Chapter were urged by Doctor Caravati to avail themselves of opportunities afforded by the Department of Continuation Education for lecture series and refresher courses, under the leadership of Dr. Kinloch Nelson.

Mrs. Helen M. Seller, assistant secretary, presented the Association's program for the current year, which includes expansion of Alumni services and the organization of new chapters in various areas of the country.

Doctor Patterson, the state president, was authorized to organize regional chapters in the following areas in West Virginia: Charleston-Huntington, Beckley-Bluefield, Clarksburg-Fairmont-Wheeling, and Keyser-Martinsburg-Winchester (Va.)

A committee composed of Drs. Carl B. Hall, of Charleston, A. U. Tieche, of Beckley, A. E. Neal, of Clarksburg, and Robert W. Bess, of Keyser, was appointed to help organize the regional chapters.

The banquet meeting was attended by over 80 members of the MCV Alumni located in West Virginia.

BALANCE, RESERVE AND TOLERANCE NEEDED

Let us assume that the Wagner-Murray-Dingell Bill was enacted into law. How long can you hold out in a strike against the Government? How many members of the medical profession could stick it out for a year with no income? If you witnessed a small majority group getting all the income, would you weaken? How many of us would give up the practice of medicine and embark on a different career? If Federal compulsory health insurance became the law in the United States, a large majority of the medical profession would be forced by circumstances to accept it—no matter how bitter its members might feel.

First, foremost and always we are doctors of medicine. Now, as never before, we need Balance, Reserve and Mutual Tolerance among ourselves—in our quest to inspire the confidence of the man-on-the-street, by giving him the facts in an Honest and Truthful manner, so that he can come up with the right answer.—New York Medicine.

SECTIONS AND SOCIETIES NAME NEW OFFICERS AT 83RD ANNUAL MEETING

The following officers of Sections were elected at the 83rd annual meeting of the West Virginia State Medical Association at White Sulphur Springs, July 27-29, 1950:

Internal Medicine: William A. Thornhill, Jr., Charleston, President, and A. B. Curry Ellison, Charleston, Secretary.

Orthopedic Surgery: Howard A. Swart, Charleston, Chairman; Robert T. Humphries, Clarksburg, Vice Chairman; and Dean L. Hosmer, Bluefield, Secretary.

Surgery: T. Kerr Laird, Montgomery, Chairman, and Robert C. Bock, Charleston, Secretary.

Urology: Clifton J. Reynolds, Bluefield, President; Thomas G. Reed, Charleston, Vice President; and John F. McCuskey, Clarksburg, Secretary-Treasurer.

Officers of affiliated societies and associations were elected as follows:

West Virginia Society of Anesthesiologists: Newman H. Newhouse, Charleston, President; Eldon B. Tucker, Morgantown, Vice President; and S. Elizabeth McFetridge, Shepherdstown, Secretary.

West Virginia Obstetrical and Gynecological Society: Charles L. Goodhand, Parkersburg, President; Alfred M. Dearman, Parkersburg, Vice President; and Clarence H. Boso, Huntington, Secretary.

Association of Pathologists of West Virginia: Siegfried Werthammer, Huntington, President; and Melvin L. Hobbs, Morgantown, Secretary.

RELOCATIONS

Dr. A. C. Thompson, of Charleston, who has just completed a residency at Charleston General Hospital, has moved to Elkins, where he will continue the practice of his specialty of internal medicine. He has offices in the Watts-Sartor-Lear Building.

* * * *

Dr. Claude Frazier, of Huntington, has moved to Ansted, where he will continue in general practice.

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Dr. K. J. Kroack, of Elkins, has located at New Albin, Iowa, where he will continue in general practice.

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Dr. George F. Grisinger, Jr., of Charleston, has accepted a three-year residency in radiology at Jackson Memorial Hospital, in Miami, Florida, and assumed his new duties there early in August. Doctor Grisinger has been associated with his father, Dr. George F. Grisinger, since his release in 1947 from the Medical Corps of the Navy after five years' active service.

* * * *

Dr. Arthur R. Fleming, of Weston, has moved to Baltimore, where he has accepted a residency in obstetrics and gynecology at Mercy Hospital.

* * * *

Dr. Archibald D. McCoy, of Wardensville, has moved to Mundelein, Illinois, where he will continue in general practice. He has offices at 334 High Street.

CHAMPIONSHIP GOLF TROPHY WON BY PRESIDENT CHARLES E. WATKINS

More than eighty doctors participated in the medical golf tournament held in connection with the 83rd annual meeting of the West Virginia State Medical Association at White Sulphur Springs, July 27-29. This set a new record for participants in golf tournaments sponsored by the State Medical Association.

The President of the Association, Dr. Charles E. Watkins, of Oak Hill, won the championship trophy, offered by Kloman Instrument Company, Inc., of Charleston. Doctor Watkins last year retired a similar championship trophy by winning three tournaments.

Other awards were made as follows: Low net (tie), Dr. Herbert M. Beddow, of Charleston, and Dr. Richard V. Lynch, Jr., of Clarksburg; low putts, Dr. Edward Vacheresse, Jr., of Fairmont; high gross, Dr. A. J. Villani, of Welch; most sixes, Dr. Jacob W. Schoolnic, of East Liverpool, Ohio, and Dr. L. Rush Lambert, of Fairmont; most putts, Dr. George Allen, of Lumberton, North Carolina; and high score on one hole, Dr. George H. Traugh, of Fairmont.

The committee which had charge of the tournaments was composed of Dr. R. R. Summers, of Charleston, chairman; Dr. Olin T. Coffield, of New Martinsville; and Dr. R. O. Halloran, of Charleston.

PERSONNEL CHANGES AT HEADQUARTERS

Mrs. Paul N. Burkhart, who has been a member of the headquarters staff of the West Virginia State Medical Association for the past three years, has moved with her family to Victoria, Texas. Mr. Burkhart, who has been a member of the executive staff of the Dupont Company at Belle for several years, has been transfered to that city.

Mrs. Burkhart has served as secretary to Charles Lively, Executive Secretary of the Association, since the resignation of Miss Catherine Clarkson early in January, 1949.

Mrs. Frank W. Sewell, a former member of the staff, succeeds Mrs. Burkhart. She assumed her new duties August 1. Mrs. Sewell was a member of the staff from 1944 until 1947.

Miss Mary Wheeler, who has been attached to the headquarters offices since November, 1949, remains as a member of the executive staff.

DR. ROGERS HEADS HUNTINGTON HOSPITAL

Dr. Wallace R. Van Den Bosch, USNR, of Huntington, who was named acting head of Huntington State Hospital, following the death on July 18, of the superintendent, Dr. Edward F. Reaser, was called to active duty as a Lieutenant (jg) in the Navy, effective July 2. He was assigned to the processing section of the Huntington Naval Recruiting Station.

Dr. Weaver B. Rogers, member of the medical staff at the hospital, has been designated acting superintendent by the Board of Control. He has been in charge of the medical and professional and personnel records of the hospital for several months.

MLB LICENSES 40 DOCTORS

At a meeting of the Medical Licensing Board, held July 10-12, 1950, at Charleston, forty doctors were licensed to practice medicine in West Virginia, seventeen by direct examination, and twenty-three by reciprocity with other states.

The following is the list of doctors licensed by direct examination:

Barnett, Charles Henry, Parkersburg
Beebe, Milton Omar, Jr., Gary
Bing, John Paul, Mount Hope
Byrne, William Draper, Rensford
Clymer, Vernon Dale, Berkeley Springs
Drake, Benjamin Michael, Charleston
Gale, Larrey Bernard, Newport, Ohio
Greene, Joseph Elmo, Clendenin
Hewitt, Lawrence Benjamin, Madison College, Tennessee
Howell, William Herbert, Jr., Morgantown
Hoylman, George Thompson, Gassaway
Kessel, James Staats, Ripley
Marple, William Kessler, Huntington
Nelson, Irving Robert, Coal Mountain
Quisenberry, Rhodes Woodford, Huntington
Stephens, Richard Samuel, Bluefield
Warnock, Jack Clarence Woodson, Huntington

The following doctors were licensed by reciprocity:

Adler, John Craige, Glenalum
Bray, William Edward, Jr., Huntington
Cook, William Cassius, Jr., Charleston
Decker, Alfred Mills, Wheeling
Dickey, Thomas Oscar, Jr., Woodsfield, Ohio
Gatti, Frank Giovanni, Beatrice, Nebraska
Goldfarb, Martin Samuel, Charleston
Haines, Innes Correll, Williamson
Huntley, Henry Clay, Charleston
John, Winfield Clinton, Huntington
Kugel, Julius Dennis, Charleston
Lewin, Julian Raymond, Beckley
McDonnell, Edmond Joseph, Baltimore, Md.
Myhree, Earl Peter, Gary
Noe, Joseph Thomas, Chester
Nunley, Wallace Clay, Rupert
Phelps, M. D., Jr., Fairmont
Reneke, Edward Joseph, Jenkinjones
Silenskey, John James, Morgantown
Thompson, James Alpha, Pittsburgh, Pa.
Walter, Eric William, Quinwood
Warga, Philip William, Parkersburg
Wilson, Robert Stringer, Clarksburg

It is a coincidence that a like number of doctors (forty) were licensed at the July meeting of the Medical Licensing Board in 1949. A total of twenty-eight doctors were licensed by direct examination and reciprocity in April, 1950.

The next meeting of the Medical Licensing Board for the purpose of examining applicants for licensure in West Virginia will be held at Charleston, October 2-4, 1950.

AMA INTERIM SESSION AT CLEVELAND

The 1950 clinical or interim session of the American Medical Association will be held in Cleveland, December 5-8. The session was originally planned for Denver, but was moved to Cleveland on account of the delay in construction of the new Denver auditorium, where the meeting was to have been held.

SURVEY SHOWS DOCTOR DISTRIBUTION

A new survey, "Number of Physicians in the United States by County," based on the new, 18th edition of the American Medical Directory, has been compiled by the American Medical Association and is now ready for distribution.

Valuable information concerning the distribution of physicians in every state is included in the survey, which subdivides the total number of physicians in the United States (201,277) into the following seven counts by county: General Practice; Practice Limited to Specialty; Special Attention to Specialty; Not in Private Practice; Retired or Not in Practice; Hospital Service; and, Government Services.

The survey also shows the number of physicians in the 23 largest cities of the United States and separate tabulations by county show the number of members of county medical societies as well as Fellows of the American Medical Association.

The price of the survey is $20.00 and copies may be obtained by writing to the Directory and Biographical Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

MLB MEETS OCTOBER 2-4, 1950

The fall meeting of the Medical Licensing Board will be held at the Capitol, in Charleston, October 2-4, for the purpose of examining applicants to practice in West Virginia.

DR. REED NEW CHAIRMAN OF EMS COMMITTEE

Dr. Thomas G. Reed, of Charleston, has been named chairman of the Committee on Emergency Medical Service to succeed Dr. Russel Kessel, of that city, and Dr. J. J. Lawless, of Morgantown, has been named a member of the committee.

The appointments were made by Dr. Charles E. Watkins, President of the State Medical Association, at the request of the Council.

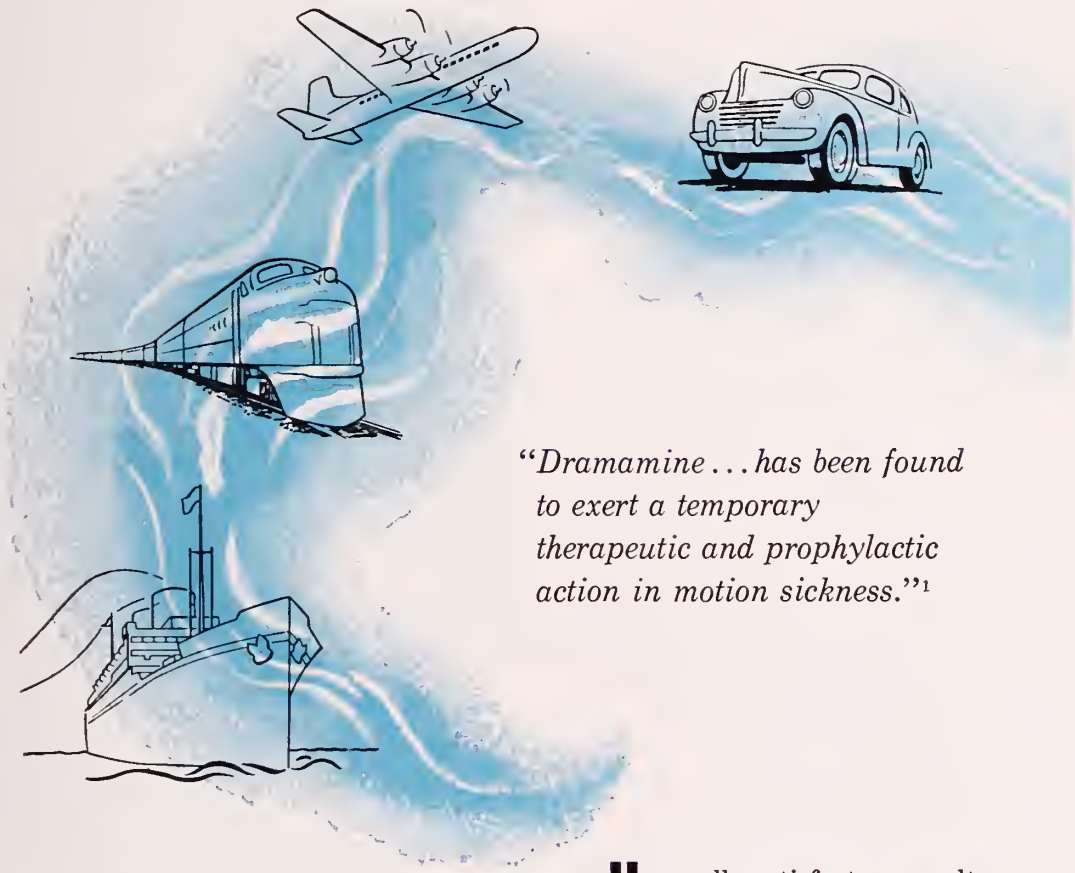
Doctor Kessel asked to be relieved of the chairmanship for the reason that he is a member of the Medical Corps of the USNR and did not feel that he could continue as chairman. He will retain his membership on the committee, together with Dr. L. Rush Lambert, of Fairmont, and Dr. Ward Wylie, of Mullens, and the two new members named by Doctor Watkins.

POLIO PLANNING COMMITTEE NAMED

A state poliomyelitis planning committee was organized at a meeting held July 24, 1950, in the office of Dr. N. H. Dyer, state director of health, in Charleston. Officers were chosen as follows:

Chairman, T. Sterling Evans, state representative, National Foundation for Infantile Paralysis; vice chairman, N. H. Dyer, M. D., Charleston; and secretary, Miss Lillian Serey, of Huntington, executive secretary of the West Virginia Society for Crippled Children and Adults.

The new committee has pledged full cooperation with the State Health Planning Committee recently set up by Governor Okey L. Patteson.



"Dramamine . . . has been found to exert a temporary therapeutic and prophylactic action in motion sickness."[1]

Dramamine

for the Prevention or Treatment of Motion Sickness

Unusually satisfactory results have been obtained with Dramamine* (brand of dimenhydrinate) as a prophylactic or active therapeutic agent for the relief of nausea, vomiting or dizziness, which many individuals experience in travelling by ship, airplane, train and other vehicles.

1. Council on Pharmacy & Chemistry: New and Nonofficial Remedies, 1950, Philadelphia, J. B. Lippincott Co., 1950, p. 460.

*Trademark of G. D. Searle & Co., Chicago 80, Ill.

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

NEW FILM ON ARTHRITIS

A motion picture for the medical profession is being made by the Arthritis and Rheumatism Foundation for the purpose of providing a better understanding in the profession of the scope and status of arthritis and rheumatism.

The film, a 16mm. color production with commentator, reviews the incidence and economical and social significance of arthritis and rheumatism. Case histories will stress the importance of hormone therapy as a guidepost to a fuller understanding of the disease.

The film, which is being produced under the supervision of the Foundation's Medical and Scientific Committee, will be completed about September 1, 1950, and copies will be supplied to groups after that date. There will be no expense attached to the showing of the film except shipping charges.

Full information concerning the new film may be obtained from Dr. Gideon K. de Forest, Medical Director, 535 Fifth Avenue. New York 17, New York.

TB AND HEALTH ASSOCIATION AT BLUEFIELD

Dr. Edward T. Blomquist, assistant medical director of the division of tuberculosis, USPH, Washington, D. C., and Mr. James G. Stone, of the National Tuberculosis Association, New York City, will be guest speakers at the annual meeting of the West Virginia Tuberculosis and Health Association, which will be held at the West Virginian Hotel, in Bluefield, September 20-21.

A breakfast X-ray symposium, featuring unusual chest conditions, has been arranged for Thursday morning, September 21. Dr. E. Lyle Gage, of Bluefield, will preside, and Dr. V. L. Kelly, of the Bluefield Sanitarium, will lead the discussion. Assisting will be Dr. H. S. Edwards, superintendent of Pinecrest Sanatorium, Dr. A. L. Starkey, superintendent of Hopemont Sanatorium, and Dr. J. H. Nelson, superintendent of Denmar Sanatorium.

Mr. E. P. "Bob" Wells, executive secretary of the Maine Tuberculosis Association, and former executive secretary of the West Virginia Tuberculosis and Health Association, will be the guest speaker at the banuet.

JAMA FREE TO MEMBERS IN 1951

The Board of Trustees of the American Medical Association, at a meeting held in San Francisco in connection with the annual convention there late in June, continued dues of $25.00 per member for the calendar year 1951.

Beginning January 1, all members who pay their dues will receive without charge the Journal of the American Medical Association for one year.

Fellowship dues have been reduced from $12.00 to $2.00, and Fellows will have the option of substituting some other publication of the American Medical Association for the JAMA. If another journal is selected by the Fellow then he will not receive the JAMA unless he subscribes for it at the rate of $12.00 per annum.

The privilege of substituting some other publication of the AMA for the Journal does not extend to members who are not Fellows of the scientific assembly.

GP ACADEMY SPONSORS FALL MEETINGS

The West Virginia Academy of General Practice is sponsoring a meeting at the Windsor Hotel in Wheeling, Sunday, September 10. One of the guest speakers will be Dr. Joseph C. Staley, professor of neuropsychiatry at the University of Pittsburgh School of Medicine. He will discuss some phase of psychiatry.

The program had not been completed as this issue of The Journal went to press, but a news story concerning the program will be released by the Academy late in August.

Other meetings sponsored by the Academy will be held during the fall and early winter months in Beckley, Clarksburg and Bluefield.

DIABETES ASSOCIATION ELECTS

Dr. George P. Heffner, of Charleston, was elected president of the West Virginia Diabetes Association at the organization meeting held at White Sulphur Springs, July 29. Other officers were elected as follows: Oliver H. Brundage, Parkersburg, vice president; William M. Sheppe, Wheeling, president elect; Richard V. Lynch, Clarksburg, secretary; and Richard N. O'Dell, Charleston, treasurer.

Doctor Heffner has been serving as chairman of the diabetes committee of the West Virginia State Medical Association.

STATE BOARD OF HEALTH MEETS SEPT. 14

The fall meeting of the State Board of Health will be held, September 14, at the Capitol, in Charleston.

ALL THIS WITHOUT FEDERAL AID

One of the oldest, albeit weakest arguments used by the Welfare Staters has been that to make insurance against sickness available to the masses in the United States there must be compulsion by law. The implication is that the people are too dumb and/or too improvident to look out for their own welfare.

If there has been any effort on the part of our federal government to acquaint its citizens with the benefits of voluntary coverage in this field we have failed entirely to notice it. Yet, within less than a decade of public education by the medical profession and allied groups more than half the population carries some form of health and hospital insurance.—Nebraska St. Med. J.

WELFARE TREND CAN BE STOPPED

Now and again some physician says, "The welfare trend is here. We can't stop it. Let's just compromise and salvage what we can."

That in my opinion is the worst type of defeatism. It does not demonstrate a broad-minded tolerance for alternative viewpoints as, superficially, it would seem to. No, it's cowardly thinking, lazy thinking and it has not even the saving grace of logic.—F. J. Elias, M. D., in Minnesota Medicine.

At one time, hospitals weren't havens for the sick at all. They were simply institutions for the care of orphans and helpless children.—R. N.

WEST VIRGINIA STATE MEDICAL ASSOCIATION

302 Atlas Bldg., Charleston, W. Va.

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President: CHARLES E. WATKINS, Oak Hill
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GEO. F. EVANS (1951), Clarksburg

A. M. A. Alternates:
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JAMES L. WADE (1951), Parkersburg

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J. C. LAWSON (1951), Williamson

Sixth District:
RUSSEL KESSEL (1950), Charleston
D. C. ASHTON (1951), Beckley

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Cancer

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Revision of Constitution and By-Laws

Sobisca S. Hall, Clarksburg, Chairman; R. A. Updike, Montgomery; Ben W. Bird, Jr., Princeton; W. T. Booher, Wellsburg; and W. W. Huffman, Gassaway.

DPA Advisory

Hugh A. Bailey, Charleston, Chairman; H. M. Beddow, Charleston; and T. Kerr Laird, Montgomery.

Fact Finding and Legislative

D. A. MacGregor, Wheeling, Chairman; Frank V. Langfitt, Clarksburg; Ward Wylie, Mullens; Russel Kessel, Charleston; Thomas L. Harris, Parkersburg; J. N. Jarrett, Oak Hill; and R. P. Daniel, Pemberton.

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SPECIAL COMMITTEES

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Mental Hygiene

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UMW Advisory

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SECTIONS

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Industrial Health

V. L. Chambers, Huntington, President (Deceased); and H. M. Brown, Belle, Secretary.

Internal Medicine

William A. Thornhill, Jr., Charleston, President; and A. B. Curry Ellison, Charleston, Secretary.

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Urology

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Scientific Assembly, W. Va. Heart Association

John E. Stone, Huntington, President; Lawrence B. Gang, Huntington, Vice President; Wade H. Rardin, Beckley, Treasurer; and Fred Richmond, Beckley, Secretary.

West Virginia Ob. and Gyn. Society

Charles L. Goodhand, Parkersburg, President; Alfred M. Dearman, Parkersburg, Vice President; and Clarence H. Boso, Huntington, Secretary.

Association of Pathologists of W. Va.

Siegfried Werthammer, Huntington, President; and Melvin L. Hobbs, Morgantown, Secretary.

Resolutions Adopted

The following resolutions were adopted by the House of Delegates at the 83rd annual meeting of the West Virginia State Medical Association at the Greenbrier, in White Sulphur Springs, July 27-29, 1950:

1. By Robert C. Back, M. D., Charleston: Artifical Fluoridation of Municipal Drinking Water.

WHEREAS, several separate and independent surveys have proven natural fluorine in drinking water does lower the caries rate well below the national average; and,

WHEREAS, the professional and lay press is calling the attention of the public to the benefits of drinking water with 1:1,000,000 of fluorine content; and,

WHEREAS, people, and especially parents, are becoming interested in ever increasing numbers in fluorine as an agent in reducing the caries rate; and,

WHEREAS, in several sections of the nation where municipal water supplies have been artifically fluoridated no untoward effects have been noted; and,

WHEREAS, the West Virginia State Department of Health, anticipating the demand, has prepared a code under which artificial fluoridation may be accomplished; and,

WHEREAS, analysis of numerous drinking water supplies from both deep wells and surface source disclose an average of a bare trace of natural sodium fluoride:

THEREFORE, BE IT RESOLVED, That The West Virginia State Medical Association, in regular session in White Sulphur Springs, West Virginia, July 27, 1950, does approve the artficial fluoridation of municipal drinking water supplies according to the regulations governing such artificial fluoridation as prepared by the West Virginia State Department of Health.

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2. By Sabisca S. Hall, M. D.,Clarksburg: The ASTP and V-12 Training Program.

WHEREAS, there is need for young physicians in the armed forces of the United States at the present time; and,

WHEREAS, there has not been sufficient response from the young physicians of our country; and,

WHEREAS, a recent editorial dated July 22, 1950, in the Journal of the American Medical Association states:

"By the time of the Pearl Harbor attack, in December, 1941, some 11,000 civilian physicians had already left their homes and practices to furnish medical support to the expanding armed forces of this country. About one year later the number had increased to 42,000, all on a voluntary basis. At the same time several thousands of premedical and medical students were deferred from active military duty to colleges and universities throughout the country to complete their medical training with a view to being called to the armed forces later to serve as medical officers.

"At this time there is evidence of probable need once again for additional medical officers to support our increasing defense establishment. Budgetary allowances have been increased for additional enlistments. The President of the United States has authorized an increase of these enlistments to augment the present troop strength and has stated that this authorization includes medical officers. There are many young physicians in the country whose services were deferred during the war in order that they might complete their medical education in either ASTP or V-12 programs, and many others have received their intern training in the hospitals of the armed forces.

"The moral obligation that rests on them to serve the nation in this time of need is clear and unequivocal. While it is true that services of many other persons were deferred and that they received training in various specialties during the war, there were few groups other than physicians who could later utilize their training to advantage in civilian life."

THEREFORE, BE IT RESOLVED, That the West Vrginia State Medical Association use its influence to induce these men to enter our armed forces as requested by the government; that a letter be written to each and every such physician by the West Virginia State Medical Association informing them of this action; and that a copy of this letter be sent to the Surgeon General of the United States Army and the Surgeon General of the United States Navy.

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3. By V. L. Peterson, M. D., Charleston: Increase in Appropriations for Treatment of Cancer.

WHEREAS, since the implementation of the program of the Cancer Control Division of the State Department of Health in July, 1944, a total of 3,701 patients have been accepted for treatment; and,

WHEREAS, statistics are now available showing the results of those patients treated during the first year of operation of this program, such statistics showing that of the 503 cases accepted for treatment, where the outcome is known at the present time, 126 are now living five years after treatment; and,

WHEREAS, it has come to the attention of the Cancer Committee of the West Virginia State Medical Association that hospital rates have been increased from $8 to $12 per diem for the care of these cancer patients, thereby nullifying any past increase in appropriations, and resulting in placing the Cancer Control Program in a precarious financial condition necessitating an overly strict screening of patients eligible for treatment for the last four months of the fiscal year ending June 30, 1950, there being a total lack of funds for the last month of that fiscal year; and,

WHEREAS, it is evident that this money has been expended wisely and in such a manner as to benefit the people of the State of West Virginia;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association go on record as favoring the program and petition the Cancer Division of the West Virginia Department of Health to in-

crease its budget request from $75,000 to $100,000 for the treatment of Cancer in order that no person or persons who needs but cannot afford such treatment which can offer hope of cure may be deprived of the opportunity of receiving same; and,

BE IT FURTHER RESOLVED, That a copy of these resolutions be transmitted to the Cancer Division of the West Virginia Department of Health, and to each member of the West Virginia Legislature.

GP AT THE CROSSROADS IN ENGLAND

The amount of money being spent on hospitals, specialists, eyes, and teeth obscures the most important problem of modern medicine—the status of general practice.

General practice is at the crossroads. The general practitioner sees himself being elbowed out of the hospital, finds himself more isolated than ever before from his colleagues in specialist and consulting practice, is plagued with paper work, and sees little prospect of obtaining those pleasant conditions of work so alluringly offered to him by the propagandists for the National Health Service during the years before July, 1948.

In the absence of hard constructive thinking and action flowing from it there is a grave risk that general practice will deteriorate and cease to attract into its ranks a goodly proportion of men and women of first-class ability—the men and women who set the high standards for others to follow.

It is infinitely harder to be an able general practitioner than to be an able specialist. Yet in the N.H.S. the bait is set to attract the latter and almost to repel the former.

Standing at the crossroads, the general practitioner may by turning in one direction become little more than a medical orderly, or by turning in another directio may be tempted to become a half-fledged specialist. If he is to go forward to occupy the most responsible position in the practice of medicine fully equipped and with confidence in his high calling, he must pause and take stock of a situation which in the view of many shows signs of rapid deterioration.—British Medical Journal.

THE TURNING OF THE TIDE?

The defeat of Senator Claude Pepper of Florida is a victory for majority views of the Medical profession, that medical care should not be administered by compulsory health insurance.

Throughout the world the socialistic tide is receding. The main socialist cry for public ownership of the means of production is beginning to lose its magic charm of socialist leaders—and for a very simple and obvious reason politically imposed socialization gives to these leaders responsibilities they are not qualified to meet. The lowered efficency and habitual deficits of socialized medicine in England are generally known. It is the difference between Utopia and Utility, between Dreams and Deeds, between Fantasy and Fact.—New York Medicine.

ANNUAL REPORTS*

CANCER COMMITTEE

During the past year, your cancer committee has endeavored to stimulate the interest of the physicians of this state in the battle against malignant diseases. The members of the committee feel that the work that is being done to fight cancer has not been stressed sufficiently in the Association in the past, and we recommend that more emphasis be placed upon this type of work in the future.

At its first meeting this year, your committee endeavored to have part of the program at White Sulphur Springs devoted to cancer, but due to the fact that arangements had been completed, we were unable to obtain a place for a speaker. However, we strongly recommend that, if possible, we have some outstanding authority to speak to us on cancer at the annual meeting next year.

An effort was made to have all the component societies appoint an active cancer committee. Twenty-four societies out of the twenty-nine responded to this request. We also asked all component societies to have a cancer program during April. We feel that the work of the West Virginia Cancer Society can be greatly enhanced if each medical society has an active cancer committee upon which they can call for advice and aid in this great work.

We feel that the best work of the West Virginia Cancer Society is being done in localities where there are physicians who are active and interested in the work against cancer.

Your committee will have presented to the House of Delegates for its approval a resolution calling for the appropriation of more funds by the West Virginia Legislature for the Cancer Division of the West Virginia Department of Health. This is being done because, due to lack of funds, the Cancer Division was forced to curtail its work during the last three months of the fiscal year.

We are pleased to report that at present there are ten cancer clinics operating in West Virginia. Seven are fully approved by the American College of Surgeons. After a thorough study of the reports of the American College of Surgeons on these ten clinics, it would appear that the programs are being criticized mainly because of the need for improvement in case records (with special reference to follow up reports), the need for improvement in the maintenance and expansion of professional educational programs, and the need for the employment of full-time secretaries in certain clinics.

Your committee feels that our state can be justly proud of these cancer clinics, and every effort should be made to encourage in every way those who are responsible for the work that is being done.

The members of the committee express their thanks and appreciation to all members of the Association, and

*Other reports were published in the August, 1950, issue of the West Virginia Medical Journal.

LIBRARY OF THE

especially to Mr. Charles Lively, Executive Secretary, for aid in the work of the cancer committee during the past year.

Respectfully Submitted,

Philip W. Oden, M. D.,
Chairman,
Chauncey B. Wright, M. D.
Thomas Bess, M. D.
Harry C. Fleming, M. D.
V. L. Peterson, M. D.
M. L. Hobbs, M. D.

COMMITTEE ON EMERGENCY MEDICAL SERVICE

In May, 1950, upon authorization of Dr. Charles E. Watkins, President of the State Medical Association, the chairman of your committee attended a nation-wide meeting devoted exclusively to emergency medical service. The meeting was held at the headquarters offices of the American Medical Association, in Chicago, and was attended by representatives from thirty-six states. It was a most interesting and beneficial meeting from the standpoint of information.

Some of our states and territorial possessions have formulated very extensive and comprehensive sets-up for emergency medical service. These naturally are very important in heavily populated areas, such as New York, Philadelphia, Washington, Baltimore, Norfolk, Houston, San Francisco, San Diago, Chicago, and numerous other urban communities. Certain recommendations were made and the National Committee feels that the local committees of each state and community should take the initiative in preparing for catastrophic emergencies as well as atomic warfare.

Early this year the State Medical Association was requested to send a physician or a number of physicians with the proper background to Western Reserve University to participate in a series of lectures concerning the care and treatment of casualties in case of an atomic attack or for other catastrophic emergencies. Since the time was short, the chairman of your Emergency Medical Service Committee, together with the Secretary of the State Medical Association, visited Governor Okey L. Patteson, and discussed the situation with him.

Following our conference with the Governor, we had an interview with Brigadier General Fox, Adjutant General of West Virginia, who is in charge of the overall state committee.

Following the conference with General Fox, it was recommended that Dr. J. J. Lawless, of West Virginia University School of Medicine, be nominated to attend the lectures at Western Reserve University, and President Irvin Stuart authorized Doctor Lawless go to Cleveland, where he spent one week taking the above designated course of lectures.

Doctor Lawless is now in a position to transmit the information he received down through the proper channels so that every physician in West Virginia may know how to care for such injuries.

In addition to Doctor Lawless taking the course at Western Reserve University on atomic injuries, our State University sent one or two of its professors to Oak Ridge, Tennessee, where they were given a course of four or five weeks in monitoring and other allied instructions concerning atomic warfare. These gentlemen are likewise available to transmit their information down through proper channels so that all necessary personnel may be acquainted with the information received by them concerning the matter.

On Wednesday afternoon, July 26, 1950, prior to the Council meeting at The Greenbrier Hotel, your Committee met and discussed certain matters concerning the above recited facts. In addition to the Committee, composed of Dr. L. Rush Lambert, of Fairmont, and Dr. Ward Wylie, of Mullens, Dr. Thomas G. Reed, Chairman of the Council of the State Medical Association, and a member of the Governor's Committee on Emergency Medical Care, and Dr. J. J. Lawless attended the meeting. Doctor Wylie was prevented from attending by reason of illness in his family.

The committee recommends that the State Medical Association sponsor two one-day meetings at which Doctor Lawless may give instructions to designated physicians so that they in turn may return to their County Medical Society and instruct their own members concerning proper care of casualties from atomic warfare. It is recommended that one meeting be held in Clarksburg, and the other in Charleston, and it is further recommended that each component Medical Society of the State Medical Association send to the meeting a member in ratio of one member to each fifty or percentage thereof of its entire membership. The committee believes that the State Medical Association, in its present financial condition, should not bear the brunt of any expenses incurred.

It is also recommended that the State Department of Health be requested to send representatives to the meetings, and that all County Health Officers be invited to attend. It is further recommended that all industries in the state which have a full-time medical department be invited to participate in the meetings.

In view of the fact that the writer is a member of the Medical Corps of the United States Naval Reserve, and that at the Chicago meeting it was stressed that Reserve Medical Officers should not be placed in responsible committee positions in Emergency Medical Service, the committee feels that the present chairman of the Committee should be replaced, and we are unanimous in our recommendation to Doctor Watkins that Dr. Thomas G. Reed, who is a member of the Governor's statewide committee, be named as chairman and that Dr. J. J. Lawless be included as a member of the committee.

Doctor Lawless will brief his lecture in a mimeographed essay so that copies may be available to the physicians taking the one-day course of lectures so they may return to their local medical societies and brief the individual physicians with necessary information concerning the care of atomic casualties.

Respectfully submitted,

Russel Kessel, M. D.,
Chairman,
L. Rush Lambert , M. D.
Ward Wylie, M. D.

REPORT OF EXECUTIVE SECRETARY

The activities of the West Virginia State Medical Association early in the year were centered chiefly upon a legislative program that included the creation of a four-year school of medicine and dentistry in West Virginia, and the entire reorganization of the State Health Department. The 1949 session of the legislature is history, and all of our members know that the bill providing for the creation of the four-year school did not become law, but that the bill providing for the reorganization of the State Health Department was passed without material change.

The reasons for the failure of the legislature to pass the bill creating the four-year school of medicine and dentistry are too well known to need repetition in this annual report. The striking part of the whole matter is that there is apparently much more interest today on the part of the lay public in the establishment of the school than there was just a few months ago.

Four-Year School

The very fact that the need for doctors in critical areas is growing worse than better, coupled with the recommendations of the deans of two medical schools, who were asked by the legislative interim committee to make a survey, that West Virginia should provide a complete medical education for her own students, seems to have awakened the public to the need for such a school and the advisability of building it without further delay.

It is significant that the Fact Finding and Legislative Committee and the Council unanimously agreed upon a plan for the setting up of a medical education fund. This whole matter is being presented to the House of Delegates for action at this annual meeting..

We are told that the recommendations of Dean Herman D. Weiskotten, of Syracuse University School of Medicine, and Dean Wilburt C. Davison, of Duke University School of Medicine, will be considered further by the legislative interim committee prior to the next regular session of the legislature, which convenes in January, 1951.

No definite decision has been reached by the Council or the Fact Finding and Legislative Committee concerning the introduction in the legislature of a bill carrying out the ideas of the members of the Fact Finding and Legislative Committee and the Council, but it is thought that the whole matter of medical education will be given consideration at meetings which will be scheduled for early fall.

PR and Congress

While the program of the State Medical Association early in the year chiefly concerned legislative matters, activities centered after March, 1950, on opposition to certain bills and resolutions before Congress.

The Public Relations Committee, with the full support of the Council and various other Association committees, went all out in a program designed to win support for the resolution opposing Reorganization Plan No. 27. The vote on the resolution which, in effect, opposed the reorganization, showed that three West Virginia congressmen voted with those opposing the plan, and two with forces favoring the plan. One congressman was absent and not voting, and the breakdown of the vote has been reported through a PR News Letter, as well as The Journal.

Although hostilities in Korea seemed to be dampening the spirits of advocates of socialized medicine, the members of the State Medical Association are not being lulled into any sense of false security in the matter of compulsory health insurance, and doctors in most every part of our state are keeping in close touch with their Congressmen. It is encouraging to note that the ranks of those making an open fight against this vicious type of legislation are increasing almost daily. The interest of members in the views of Congressmen, as well as candidates for Congress, is very acute, and there is no doubt that every candidate for a seat in the House of Representatives from West Virginia will be asked many times during the next few weeks to stand up and be counted.

County Societies and Auxiliaries

During the past year, I have visited nearly all of the component societies, and have also visited many of the local auxiliaries.. Attendance at meetings in all of the areas over the state seems to be increasing, and it is still apparant that the societies and auxiliaries which arrange luncheon and dinner meetings obtain the attendance of a greater number of members than when meetings are called for mid-afteroon or after the dinner hour in the evening.

The decision of some of the societies which have heretofore been meeting but once in three months to hold meetings monthly is paying big dividends in the matter of attendance. Some of the societies are for the first time holding meetings through the summer months.

Another encouraging sign in the matter of stepping up interest in local meetings is the more frequent use of members as speakers on scientific programs. Some of the societies have tried local talent with a great deal of success during the past few months, and we are told that increased efforts are to be made to have more members prepare and present papers at regular monthly meetings.

Membership at All-Time High

There has been a slight increase in our total membership since the annual meeting at White Sulphur Springs, August 3-5, 1949. At that time, the membership totaled 1399. Today it is 1424, an all-time high.

Of the total, 141 hold honorary lifetime membership, another all-time high. This means that we have 1285 active members on our roster.

During the year, we have sustained a loss of 26 members by death, and 37 by relocation in other states. These losses have been more than offset by the election of 98 new members during the year.

Membership by Societies

The membership by component societies as of July 25, 1950, is as follows:

Society	*Members*
Barbour-Randolph-Tucker	47
Boone	17
Brooke	6
Cabell	161
Central West Virginia	57
Doddridge	2
Eastern Panhandle	32
Fayette	44
Greenbrier Valley	31
Hancock	19
Harrison	81
Kanawha	255
Logan	42
Marion	58
Marshall	17
Mason	4
McDowell	61
Mercer	61
Mingo	29
Monongalia	52
Ohio	109
Parkersburg Academy	89
Potomac Valley	29
Preston	16
Raleigh	63
Summers	9
Taylor	10
Wetzel	12
Wyoming	12
Total	1424

AMA Dues for 1950

A total of 1191 members have paid AMA dues for 1950. This represents a little over 92 per cent of our active members. A total of $29,775 has been collected and remitted to the American Medical Association.

We have just within the past few days received official notice of the action of the AMA House of Delegates in directing that The Journal of the American Medical Association be sent without charge to members who pay dues in 1951, and that some other publication of the AMA may be substituted for the JAMA if the members so elect. A mimeographed letter on this subject will be mailed to all of the members later in the year.

The Journal

There has been no loss in Journal advertising during the year. Some accounts have been withdrawn, but new business obtained has offset these minor losses. We still realize sufficient funds from our advertising contracts to pay for publication and distribution of The Journal, with a small surplus being shown at the end of the fiscal year. Full report concerning finances is being made to the Council by Dr. Walter E. Vest, the editor.

The quality of scientific material being submitted for publication is still pleasing to the members of the Publication Committee. Early in the spring there was a dearth of material, but an appeal made directly to county societies and to the membership generally through the columns of The Journal resulted in the submission of several papers which have been approved by the Publication Committee.

Scientific Material

We expect to obtain for publication several of the papers that will be presented at the annual meeting at White Sulphur this week, and there should be no critical shortage of scientific material during the remainder of the calendar year.

The members of the Publication Committee are, without exception, doing a very fine job in their endeavors to provide the very best scientific material for The Journal. It is not an easy matter, and the Committee as a whole deserves the thanks of the entire membership for the work that is being done.

Local Officers Lend Aid

Secretaries of local societies and auxiliaries have cooperated with us to the fullest extent in the many different matters that constantly need attention. This is a thankless job for these very efficient officers, but their prompt response when called upon for aid in a particular job has helped to make the last year one of the best in the history of the Association.

The maintenance of current rosters by county societies is a most difficult undertaking. We try at all times to have our roster of the entire membership correct, but we could not do so without the close cooperatin of the county society secretaries.

Much depends upon the work of the treasurers and the secretaries who also serve as treasurers. For two consecutive years they have been called upon to collect funds for the American Medical Association. Next year, they will have the same duties to perform. Without their full support and aid in this matter, it would be most difficult for us to continue our high standing in the matter of dues collected for the parent organization.

I extend to these faithful and hard-working officers of local societies, and to the secretaries of local auxiliaries, the sincere thanks of the headquarters staff for promptly supplying material from which news stories can be prepared for the news and organization sections of The Journal.

State Health Department Cooperates

We have had the full cooperation of Dr. N. H. Dyer and the state department of health personnel in supplying public health information to the many members who have requested material on this subject. In addition, the department deserves the thanks of the State Medical Association for maintaining a current roster of all doctors of medicine in West Virginia, including those who are not members of the State Medical Association.

It has been my very great pleasure to appear with the President, Dr. Charles E. Watkins, of Oak Hill, on programs arranged by several societies, as well as by lay groups. The President has done a magnificant job. He is available at all times for consultation in the many matters that need attention at the state headquarters offices. He and all of the other officers and the chairmen and members of the active committees deserve a vote of thanks for the work that has been done during the year.

The Public Relations Committee has again been outstanding for the work it has done in the fight against compulsory health insurance. Led by Dr. Frank J. Holroyd and the members of his always-on-the-job committee, the public relations campaign in West Virginia has been running in high gear for eighteen months. It will be good news to the membership to know that the fourth of a series of rural health conferences and the second consecutive radio-press conference are now being planned for sometime during the winter.

We have, of necessity, experienced a complete turn over of headquarters staff personnel during the past year, but have been most fortunate in obtaining replacements. The staff as at present constituted is most satisfactory and the employees are efficient in their work and tireless in their efforts to keep the work at headquarters current.

Sincerely,

CHARLES LIVELY,
Executive Secretary.

Charleston,
July 25, 1950.

NECROLOGY COMMITTEE

The following is a list of West Virginia doctors whose deaths during the past year have been reported to the West Virginia Medical Association

1949

Aug. 19 ..... James Robert Richardson, Union
Aug. 20 ..... William A. Campbell, Belington
Aug. 31 ..... Edward Leo Kaufman, Powellton
Sept. 15 ..... Russell Brooks Bailey, Wheeling
Sept. 30 ..... John Francis Barker, Huntington
Oct. 9 ..... Ralph Joseph Ford, Spencer
Oct. 24 ..... Frank Luther McNeer, Hinton
Nov. 8 ..... Samuel B. Johnson, Franklin
Nov. 17 ..... Andrew J. P. Wilson, Wheeling
Nov. 27 ..... Ernest H. Ball, Charleston
Nov. 29 ..... Okey Johnson Casto, Parkersburg
Nov. 30 ..... Virgil Lewis Chambers, Huntington
Dec. 5 ..... James Kuykendall Guthrie, Martinsburg
Dec. 14 ..... Charles Francis Mahood, Alderson

1950

Jan. 4 ..... Guilford Brown Irvine, Williamson
Jan. 6 ..... John Trevy Goff, Smithville
Jan. 28 ..... William Perry Baker, Morgantown
Jan. 28 ..... James William Hartigan, Morgantown
Jan. 29 ..... Harwood Hugo Ritter, Charleston
Feb. 2 ..... Dave S. Stewart, Creston
Feb. 6 ..... James Thompson, Morgantown
Feb. 9 ..... Robert Wanee Chambers, Beckley
Feb. 22 ..... Howard H. Veon, Parkersburg
Feb. 26 ..... Lee Otis Hill, Camden-on-Gauley
Mar. 2 ..... Robert Harold Jones, Fairmont
Mar. 2 ..... Laban Phelps Stanley, Charleston
Mar. 10 ..... Harvey Monreville Andrew, Weston
Mar. 18 ..... Roy Ben Miller, Parkersburg
Mar. 24 ..... Robert Shannon Peck, Cannelton
Mar. 31 ..... John Ewing Hughart, Hilton Village
Apr. 17 ..... Paul Lowell Douglas, Pursglove
June 9 ..... Herbert B. Wise, Weston
June 30 ..... Tyler Robert Boling, Grantsville
July 6 ..... Lorah O. Fox, Ansted
July 11 ..... Irvin C. Stump, Clendenin
July 18 ..... Edward F. Reaser, Huntington
July 23 ..... L. G. Houser, Beckley

Respectfully submitted,

R. R. Summers, M. D.,
Chairman,
C. B. Pride, M. D.
Upshur Higginbotham, M.D.
F. L. Banks, M. D.
B. F. Puckett, M. D.

COMMITTEE ON SYPHILIS

In West Virginia, as on the national scale, the trend in the number of cases of venereal disease has been steadily downward during the last four years. This trend is shown by the table below:

Venereal Disease Morbidity Reporting In West Virginia Health Department Clinics

Period	*Pri. & Sec.*	*Early Latent*	*Late & L. Latent*	*Cong.*	*Total*	*G. C.*
July '46-June '47	2149	1188	985	168	4490	4741
" '47- " '48	1462	870	1007	189	3528	4136
" '48- " '49	616	614	1014	170	2414	3826
" '49- " '50	416	317	752	108	1593	3444

Practicing Physicians

Period	*Pri. & Sec.*	*Early Latent*	*Late & L. Latent*	*Cong.*	*Total*	*G. C.*
July '46 June '47	1131	982	1232	103	3448	1942
" '47- " '48	606	670	934	55	2265	1086
" '48- " '49	585	750	1065	85	2485	881
" '49- " '50	329	557	1030	103	2019	690

State Total

Period	*Pri. & Sec.*	*Early Latent*	*Late & L. Latent*	*Cong.*	*Total*	*G. C.*
July '46-June '47	3280	2170	2217	271	7938	6683
" '47- " '48	2068	1540	1941	244	5793	5222
" '48- " '49	1201	1364	2079	255	4899	4707
" '49- " '50	745	874	1782	211	3612	4134

The decrease in early syphilis is quite striking and if these morbidity figures can be relied upon, indicate that effective progress is being made toward ultimate control. There has been relatively little change in the

reporting of late syphilis, indicating that we still have a considerable backlog from previous years.

There has likewise been relatively little change in the number of cases of congenital syphilis reported. Until very recently no breakdown by age was available and we have no way of knowing how many of these were below one year of age when diagnosed. In the twelve month period beginning March 1, 1949, 9.3% of the cases reported were diagnosed during the first year of life and 50.3% between the first and fourteenth year. It is therefore impossible to state at present whether we are dealing with a backlog of cases of late congenital syphilis or whether the number of reported cases has failed to decline as rapidly as that of early syphilis. After July 1, 1950, a complete age breakdown up to 14 years will be available.

Based on statistical reports of serological tests from private laboratories it can safely be estimated that at least twice as many cases of syphilis are seen by practicing physicians as are reported.

During the fiscal year 4,134 cases of gonorrhea were reported—690 by practicing physicians. Discussions with physicians, chiefly general practitioners throughout the State, indicate that at least as much, if not considerably more, gonorrhea is being treated privately than by health departments. There is very little evidence that the incidence of gonorrhea has decreased materially since the introduction of penicillin, but this may well be a fallacy as we now have a series of reinfections in the same promiscous individual, each reported as a new case rather than as a single chronic case.

I. Control Measures:

Successful control of venereal disease depends primarliy upon the elimination of sources of infection, as it appears there is no immediate prospect for a decrease in promiscuity.

With the decrease in incidence more effort must be expended to find each new case, that is, a larger number of persons must be screened in some manner for each new infection discovered—a condition not generally recognized. Approximately one-half of the cases of infectious syphilis are still discovered by contact investigation, the remainder by voluntary request for examination or through routine serological testing.

II. Diagnostic and Treatment Facilities:

1. Clinics—

Health department clinics are now located in nearly all of the counties, and in the few low incidence areas lacking a clinic arrangements are made with a local physician for examination at his office on a fee-for-service basis.

The primary weakness of the clinics and one of the greatest deterrents to the establishment of out-patient treatment of syphilis is the difficulty of securing the services of physicians sufficiently interested to make an adequate diagnostic examination and to give the patient the very important instructions regarding post-treatment observation, or to see that someone else does it.

At present out-patient treatment is being given for gonorrhea and chancroid only, except for a few cases of late syphilis for which heavy metals are being used prior to referral to the West Virginia Medical Center. In certain cases, such as syphilis in pregnancy discovered so near to term that transportation to the Center is not practical, out-patient treatment is authorized but must be approved by the Director of the Bureau of Venereal Disease Control.

Out-patient treatment of all types of syphilis was authorized at the clinic in the Ohio Valley Hospital in Wheeling in March, 1950, but up to May 30, 1950, only three such cases had been treated there.

2. West Virginia Medical Center—

With the exception of uncomplicated gonorrhea and chancroid, all cases of venereal disease not able to receive private treatment are referred to the West Virginia Medical Center where facilities for diagnostic studies of patients who are to receive private treatment later are also available.

As would be expected, the total caseload has decreased somewhat but there has been an increase in the number of persons sent in for diagnostic work, particularly because of the presence of non-specific genital lesions or of low serological titers causing the referring physician to suspect a biological false positive reaction.

Admissions to West Virginia Medical Center
June 1, 1949 — May 31, 1950

	In-Patient	*Out-Patient*	*Total*
Primary and Secondary	394	8	402
Early Latent	579	33	612
Late or Late Latent	648	48	696
Neurosyphilis, Early	47	2	49
Congenital	164	4	168
Gonorrhea	38	40	78
Other VD	31	6	37
No VD (Admitted for Diagnosis)	326	172	498
Total	2227	313	2540

	In-Patient	*Out-Patient*	*Total*
Admitted for post-treatment observation	233	60	293
Pregnancy complicated by syphilis	144		144

A further breakdown of the cases of late and congenital syphilis is also shown:

Late acquired syphilis		648
Late Latent	204	
Cardiovascular	33	
Neurosyphilis		
Asymptomatic	229	
Meningoencephalitis	57	
Meningovascular	26	
Tabes dorsalis	65	
Primary Optic Atrophy	9	
Ocular syphilis (Other than Primary Optic Atrophy)	6	
Cutaneous	10	
Osseous	5	
Congenital syphilis		164
Asymptomatic	84	
Interstitial keratitis	36	
Juvenile paresis	5	
Asymptomatic neurosyphilis	27	
Other	10	

III. Case-finding Activities:

Seventeen full-time lay visitors or investigators are assigned to county and district health departments throughout the State, covering most of the high incidence areas. Approximately one-half of the cases of

infectious venereal disease and many of the cases of late and congenital syphilis are discovered through their efforts in securing the examination of sex and familial contacts. In addition to contact investigation they are charged with the promotion of venereal disease education in their areas.

The special case-finding project in Wood County based on the checking with physicians of positive serological reports from the private as well as the State Laboratory was retarded by the transfer of the original visitor, but is now continuing satisfactorily with the cooperation of nearly all the physicians in the area.

IV. Serological Testing:

Since October 1, 1949, the State Hygienic Laboratory has been performing a sensitive Mazzini test on all serological specimens submitted and a quantitative Kahn on all showing a positive or doubtful reaction. This has been a great advance, particularly in the detection of biological false positive reactions. The number of patients referred to the West Virginia Medical Center for consultation and the volume of correspondence regarding the handling of patients showing low titers has appreciably increased in recent months.

Syphilis Serology on Blood and Spinal Fluid Specimens Jonuory 1, 1949 — December 30, 1949

Hygienic Laboratory Division, W. Va. Department of Health

No. Submitted and Examined	*Unsatisfactory*	*Positive*	*Per Cent Positive*
1. Total Number of Blood Specimens from *All Sources*:			
126,403	7,374	16,347	13.7
2. Blood Specimens for Premarital Certificates:			
6,482	260	236	3.8
3. Spinal Fluid Specimens for Standard Serological Test for Syphilis. (Kolmer Simplified on all specimens; Kolmer Quantitative on Reactors).			
4,075	64	962	24.0
4. Spinal Fluid Specimens for Quantitative Determination of Total Protein Content:			
			Per Cent Abnormal
4,075	89	1,114	27.9
5. Spinal Fluid Specimens for the Colloidal Gold Reaction (Lange):			
4,075	29	874	21.6

Laboratories other West Virginia Hygienic Laboratory:
Total Laboratories Approved 117
Total Laboratories Reporting ..... 74 or 63.3%

Total Syphilis Serological Examinations reporting by the 74 laboratories reporting 142,905
Per cent positive 5.7

Premarital Syphilis Serological Examinations:
Approved Laboratories 13,739
Per cent positive 2.1%
Hygienic Laboratory 6,482
Per cent positive 3.8%

Inasmuch as previous experience indicates that the number of specimens examined by the 43 laboratories from which reports are not at present available was probably roughly proportionate to the number done by the 74 reporting, it is estimated that a total of at least 210,000 specimens were examined by private laboratories throughout the State, of which at least 21,000 were for premarital purposes.

The 4,075 spinal fluid specimens examined by the Hygienic Laboratory were small, considering the total number of cases reported, 2,142 of these being from the West Virginia Medical Center and a considerable additional number taken at clinics on former Center patients. As few private laboratories do spinal fluid serological work, it is obvious that few private patients reecive this essential examination.

Of the 7,374 blood specimens received in an unsatisfactory condition by the Hygienic Laboratory, approximately 5% were rendered so by hemolysis which is usually the result of improper handling of the specimen at the time it is taken. The vast majority of these unsatisfactory specimens came from practicing physicians rather than clinics.

V. Educational Activities:

In November, 1949, a new revision of Supplement 23 of the Journal of Venereal Disease Information, "The Diagnosis of Syphilis by the General Practitioner," by J. E. Moore, M. D., was released.

Copies have been distributed to physicians throughout the State. Because of the cost and the tendency of physicians to file such material in the waste basket when received, it has been distributed through the local health departments directly to the physicians and from the Bureau of Venereal Disease Control in response to inquiries.

The Acting Director of the Bureau of Venereal Disease Control spoke before three county medical societies and at the School of Pharmacy of the University relative to recent trends in the diagnosis and treatment of the venereal diseases during the year.

The series of recorded broadcasts developed by the Communications Materials Center at Columbia University has been continued, every locality in the State having been covered at least once.

In several counties educational programs have been worked out with various lay groups such as Parent-Teachers Associations, fraternal and civic organizations by the Venereal Disease Visitors and a considerable amount of educational material distributed through these channels.

VI. Prenatal Serological Testing:

The latest figures available from the Division of Maternal and Child Health show that in infant mortality rates West Virginia ranks fourth from the top, with 40.2 deaths per one thousand live births, being exceeded by only Texas, Arizona and New Mexico, all of which states have large negro, Indian or Mexican population in which infant mortality is notoriously high whereas West Virginia has a negro population of not more than 5%. Syphilis is given as the tenth most frequent cause of infant deaths—and, of course, in this disease the error in diagnosis is quite high. Neither does this take into consideration the number of neonatal deaths or stillbirths reported as due to prematurity but actually caused by syphilis.

Present methods of treatment of the mother—even very close to term—will practically insure a healthy baby if it has not already suffered serious damage.

Unfortunately not all infected mothers are detected or treated and the principal cause is the failure of physicians to make an examination for syphilis, including a serological test—as required by law—and to follow through and see that the woman receives treatment if indicated.

A further study of the compliance with the requirement for prenatal serological testing has indicated that there are many counties in which it is very poor.

From a four month survey it appeared that while the over-all picture indicated that only about 11% of the birth certificates showed that no prenatal test was made, there was great variation between the counties as shown below:

No. Counties	*Percentage of certificates indicating that no prenatal test had been made*
17	0-10
13	10-20
13	20-30
6	30-40
4	40-50
1	60-70
1	70-80

The law regarding prenatal serological testing also requires that the blood specimen be identified as such and that a copy of the report be sent by the laboratory to the Bureau of Venereal Disease Control. Examination of these reports indicates that there is no record of a test having been made in at least 19% of the births during 1949, a much lower degree of compliance than the statements made on the birth certificates would indicate. If an allowance is made for duplication and unsatisfactory specimens this figure is probably nearer 25%.

VII. Financial Support:

Federal appropriations were reduced by about 15% last year and further cuts may be anticipated. Although less is required for treatment more must go into case-finding and real effort is now required to locate the cases which formerly could be found merely by stretching out a hand. Unless the reduction in federal funds can be made up from other sources the program will shortly have to be seriously curtailed.

VIII. Plans and Proposals for the Fiscal Year 1951:

1. Educational.

The printed material available for distribution to the comic book strata from which most of our cases come, has relatively little appeal to the people of this section, being directed largely to southern negroes and the Bureau of Venereal Disease Control with the Bureau of Public Health Education is therefore developing material which it is believed will be more useful.

Wider distribution to physicians of "The Diagnosis of Syphilis by the General Practitioner" with an insert regarding treatment schedules will continue as opportunity presents.

Continuation of the use of recorded spot broadcasts and of short fillers in commercial movie theaters is planned as material becomes available.

2. West Virginia Medical Center.

During the past year considerable progress has been made toward the development of a more generalized public health program in addition to the rapid treatment facilities. A school for the training of sanitarians has been in operation for nearly a year, and the school for public health nurses and the production unit of the Bureau of Public Health Education will be opened shortly. The headquarters of the Kanawha-Charleston Fly Control Project, which includes a considerable research program as well as the reduction of the local housefly population, is likewise located at the Center and contributes to its financial support.

As the venereal disease caseload has been reduced, beds have become available for other purposes and beginning July 1, 1950 cancer patients whose hospital costs are borne by the Division of Cancer Control will be housed at the Center for post-operative care and while receiving X-ray or radium nearby at the local hospitals. This will release a number of badly needed beds in the general hospitals and enable the Division of Cancer Control to make its funds go farther, as patients may be housed at the Center for approximately one-half the per diem rate charged elsewhere. There is no intention of developing a diagnostic cancer clinic at the Center and all patients will come through one of the existing clinics.

Admission of terminal cancer cases has been suggested, but it is believed that this is not a function of the health department, nor would the facilities available at the Center for the care of such cases permit it.

Other possibilities are being explored to enable the field of utilization of the Center to be extended in order that it may be retained as a public health center after justification for its operation as a rapid treatment center for venereal disease alone is no longer possible.

3. Out-patient Treatment.

It is anticipated that during the coming fiscal year out-patient treatment for syphilis in addition to gonorrhea will be instituted in certain health departments where facilities and interest on the part of the clinicians in doing adequate diagnostic work exist. The results of schedules using two and three injections weekly for three or four weeks in use in other states are being followed, as these are more practical for clinic use than schedules requiring daily treatment.

4. Case finding.

With the decreasing caseload in the known high incidence areas, it is now feasible to explore some of those sections in which relatively little field work has been done but where it is quite likely small and active foci of infection exist. It is therefore planned to add to the staff an investigator who will work in those areas which do not justify a full-time visitor.

Included in the project is a serological testing program on a relatively small scale as the available funds are limited—directed chiefly toward the detection of congenital syphilis. It is planned to use the reecntly developed filter paper microscopic test for which the blood is obtained on a strip of filter paper from a capillary puncture.

5. Prenatal Serological Testing.

Beginning shortly after July 1, 1950, each birth certificate coming to the Division of Vital Statistics will be examined for evidence of compliance with the law requiring a prenatal serological test. Physicians failing to comply will be contacted directly by the Bureau of Venereal Disease Control or the local health department. More complete plans are now being worked out and will be submitted later.

The primary objects of this program are:

a. To stimulate prenatal serological testing for syphilis in all pregnant women.

b. To stimulate the women to seek prenatal care early.

c. To stimulate the physicians to take a blood specimen when she reports early—and to note the results and see that she is treated if it is indicated.

d. To promote the taking of a second specimen shortly before term—it having been found that a considerable number of infections are acquired late in pregnancy.

e. To secure the examination of the other children of those women found through prenatal examination to have syphilis.

f. To insure that all women delivered by midwives receive prenatal serological tests and physical examinations by practicing physicians or health department clinics. An educational effort directed to physicians and the public is planned in cooperation with the Division of Maternal and Child Health using all available channels.

It is believed that if physicians in general become aware that some definite action is being taken regarding prenatal serologic testing there will be relatively few who will fail to comply. It is, however, planned to take such action as is necessary through either the Medical Licensing Board or the courts against persistent violators.

Respectfully submitted,

N. H. Dver, M. D.,
Chairman,
C. A. Hoffman, M. D.,
R. O. Halloran, M. D.
W. Carroll Boggs, M. D.,
Frank S. Harkleroad, M. D.

UMW ADVISORY COMMITTEE

Since our last meeting there is very little to report on the United Mine Workers Health and Welfare Fund because, due to the strike, all work was stopped, and was but recently started on a curtailed schedule.

As you have been advised, the care of these mines on Welfare was resumed on July 1, 1950, being limited to work done only in the hospital and not including home or office calls. It is easy to understand that the general practitioner will feel left out because of this ruling and the Committee has discussed this matter with the Physicians' Committee of the Welfare Fund, hoping that something might be done about this problem a little later on in the year. There is a possibility that home or office work on a limited scale may be authorized later, depending upon the condition of the Fund.

In the new set-up there have been no changes in policy, the patient still being allowed the choice of physician or hospital (all hospitals which have worked out an agreement with the Health and Welfare Fund). There is still no fee schedule for physicians, and it is expected that all doctors will make their charges commensurate with the charges made patients in the same income bracket.

In a recent conference with Dr. John T. Morrison, UMW Area Administrator, he expressed himself as being very well satisfied with the cooperation he has received from the physicians over the state, there being but few who have shown evidence of not playing fair. These cases have been handled in a very capable manner, and I personally feel that the work is being conducted on a high plane.

Inasmuch as nearly $15,000,000 was paid to hospitals and doctors during the year preceding the strike, it was inevitable that there would be some complaints. It is hoped that these problems can be settled on a local level by consultations between the Local Society Grievance Committee and the representatives of the Welfare Fund. The State Advisory Committee stands ready to help where this cannot be done. Of course, any final disciplinary action must come from the Council of the State Medical Association.

Doctor Morrison has told your committee that the work done before the strike will help those in charge to evaluate the need for medical and surgical care in a hospital.

It is the feeling of the committee that the doctors directing this work over the state are doing it on a very high plane and that every consideration is being given to the hospital and the doctor. We feel that they should be commended for the work that is being done as well as for their work in the past.

Respectfully submitted,

Ray M. Bobbitt, M. D.,
Chairman,
W. Fred Richmond, M. D.
John P. Helmick, M. D.
D. A. MacGregor, M. D.

COMPULSION VERSUS FREEDOM

After a little more than a year of socialized medicine it is becoming apparent that the British must not understand how socialism really functions. They have evidently started out to have all the advantages of an unregimented system of medical care, and all the supposed advantages of the socialistic system. They are being forced to abandon, one by one, the confidential doctor-patient relationship, the freedom of a doctor to prescribe, and, due to the greed of the people, the ability to provide free medicinals.

They are finding out that socialism is like pregnancy, one cannot have a little of either. A little socialism will slowly but surely crowd out all freedom. Socialism in one profession will slowly but surely spread to other portions of the economy.

John McPherrin, editor of The American Druggist, in an interview last year with Mr. Bevan, asked the Minister if it would not have been better to have introduced socialistic practices into England gradually and thereby have avoided many of the mistakes. Mr. Bevan's answer was to the effect that the changeover must necessarily be sudden and complete, and that the Minister must be the master.

Dictator is a better word.—Journal, Indiana St. Med. Assn.

OBITUARIES

HOLLY L. CASTO, M. D.

Dr. Holly L. Casto, 76, of Spencer, died in the Veterans Hospital at Chillicothe, Ohio, August 6, 1950. He had been in ill health for several months.

Doctor Casto received his M. D. degree from Kentucky University Medical Department, Louisville, in 1905. He was licensed in West Virginia in 1904, and had practiced at Spencer until his retirement a few years ago.

He served in the Medical Corps of the Army during World War I, and was released with the rank of Captain.

He is survived by a sister, Mrs. Dayton Rhodes, of Spencer; a half brother, Kenna Casto, of Columbus, Ohio; and a step-daughter, Mrs. F. F. McIntosh, of Spencer.

* * * *

GEORGE W. FOX, M. D.

Dr. George W. Fox, 87, of Ansted, died in a hospital at Sweet Springs, July 30, 1950. Death was due to complications incident to advanced age.

Doctor Fox received his M. D. degree from Kentucky University School of Medicine, Louisville, in 1906, and was licensed to practice in West Virginia the following year. He located at Ansted where he continued in general practice until his retirement a few years ago on account of ill health.

Besides his widow, he is survived by three brothers, Walter, of Gatewood, and Stuart and Warren, of Victor; and three sisters, Mrs. Anna Hess, of South Charleston, Mrs. Virgie Mattics, of Handley, and Mrs. Lulu Taylor, of Ansted.

* * * *

LYNWOOD GASKIN HOUSER, M. D.

Dr. Lynwood Gaskin Houser, 59, of Beckley, died unexpectedly at his home in that city, July 23, 1950. Death was attributed to coronary occlusion.

Doctor Houser was born at Elko, Georgia, son of the late Mr. and Mrs. John Houser. He received his M. D. degree in 1914 from Emory University Medical College, Atlanta, Georgia, having received his B. S. degree in 1910 from Gordon Institute. He was licensed to practice in West Virginia in 1926, having previously been located at Byron and Augusta, Georgia. He had practiced his specialty of EENT continuously at Beckley since 1926.

Doctor Houser was a past president of the Raleigh County Medical Society, and a past West Virginia Governor of Kiwanis, International.

Besides his widow, the former Pauline Honts, of Eagle Rock, Virginia, he is survived by two sisters, Mrs. Clark J. Hardaman, of St. Louis, Missouri, and

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Mrs. W. O. Gaines, of Bainbridge, Georgia, and one brother, L. A. Houser, of Elko, Georgia.

* * * *

ONA F. MITCHELL, M. D.

Dr. Ona F. Mitchell, 47, of Franklin, died unexpectedly at his home in that city June 28, 1950, following a heart attack.

Doctor Mitchell was born at Sugar Grove, January 16, 1903, son of Jacob F. and Florence (Propst) Mitchell. He received his early education in the local schools and graduated from St. John's Academy in Petersburg in 1926. He studied at Capitol University, Columbus, Ohio, and George Washington University, Washington, D. C., and received his M. D. degree from the Medical College of Virginia in 1933.

Doctor Mitchell interned at Charleston General Hospital, 1933-34, and was licensed to practice in West Virginia in 1934. He located at Franklin in 1935, where he continued in general practice until his death.

He was a member of the Potomac Valley Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Besides his widow, the former Pauline Vivian Eye, he is survived by two daughters, Kay and Judy Ann; three brothers, T. P. Mitchell, of Bealeton, Virginia, L. Lloyd Mitchell, of Washington, D. C., and Byron Mitchell, of Sugar Grove; and four sisters, Miss Elizabeth Mitchell, Mrs. Ora D. Hoover, Mrs. Edna Cone, and Miss Emma Ruth Mitchell, all of Arlington, Virginia.

SO. CHAP. ACCP AT ST. LOUIS

The 7th annual meeting of the Southern Chapter of the American College of Chest Physicians will be held at the Statler Hotel, in St. Louis, November 12-13, conjointly with the annual meeting of the Southern Medical Association.

The first scientific session is scheduled for Sunday afternoon, November 12, with Dr. Hollis E. Johnson, of Nashville, Tennessee, presiding as chairman, and the second session will be held the following morning, with Dr. Otto C. Brantigan, of Baltimore, presiding.

The President's banquet will be held at the Statler Hotel, Sunday evening, at which time Dr. David H. Waterman, of Nashville, Tennessee, will present his presidential address. Dr. Duane Carr, of Memphis, will serve as toastmaster.

An X-ray Conference will follow the banquet with Dr. Alfred Goldman, of St. Louis, presiding as moderator.

Dr. Evarts A. Graham, of St. Louis, will be the guest speaker at a luncheon which will be held at the Statler, Monday, November 13. Physicians who are in St. Louis for the annual meeting of Southern Meidcal Association are invited to attend the ACCP sessions.

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Surgery of Colon & Rectum, One Week, starting September 11, October 9.
Esophageal Surgery, One Week, starting October 16.
Breast & Thyroid Surgery, One Week, starting October 2.
Thoracic Surgery, One Week, starting October 9.
Gallbladder Surgery, Ten Hours, starting October 23.
Fractures & Traumatic Surgery, Two Weeks, starting October 9.
Basic Principles in General Surgery, Two Weeks, starting September 11.
GYNECOLOGY—Intensive Course, Two Weeks, starting September 25, October 23.
Vaginal Approach to Pelvic Surgery, One Week, starting September 8, November 6.
OBSTETRICS—Intensive Course, Two Weeks, starting September 11, November 6.
MEDICINE—Intensive General Course, Two Weeks, starting October 2.
Gastro-enterology, Two Weeks, starting October 16.
Gastroscopy, Two Weeks, starting September 11, October 23.
Electrocardiography & Heart Disease, Four Weeks, starting October 2.
DERMATOLOGY—Formal Course, Two Weeks, starting October 16. Informal Clinical Course every two weeks.
UROLOGY—Intensive Course, Two Weeks, starting September 25.
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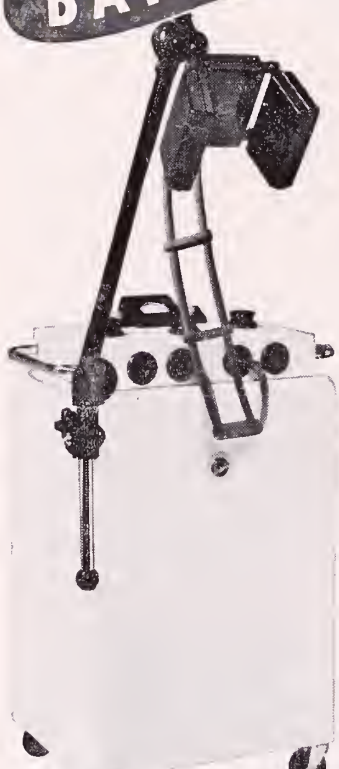

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WOMAN'S AUXILIARY

MINGO

The July meeting of the Woman's Auxiliary to the Mingo County Medical Society was held at "Fairview," the home of Dr. and Mrs. Woodrow W. Scott, and the members of the Mingo County Medical Society were invited as guests. A delicious picnic dinner was served those present.

At a brief business meeting following the dinner Mrs. W. S. Feldman and Mrs. Henry Clay Hays were named as delegates to the annual Auxiliary meeting at White Sulphur Springs, and Mrs. Woodrow W. Scott and Mrs. Robert Lawson were elected alternates.

Mrs. J. C. Lawson, the president, presided at the meeting, which was attended by 25 members of the Society and the Auxiliary.—Mrs. Henry Clay Hayes, Corresponding Secretary.

DR. DUCKETT JONES HONORED

Dr. T. Duckett Jones, of New York City, medical director of the Helen Hay Whitney Foundation, has been named by Dr. Howard B. Sprague, President of the American Heart Association, as chairman of the American Council on Rheumatic Fever of the Association.

Doctor Jones, who is well-known to many doctors in West Virginia, is a member of the board of directors of the American Heart Association, and is chairman of the subcommittee on rheumatic fever, United States Children's Bureau.

The purpose of the American Council on Rheumatic Fever is to facilitate the study, prevention, and treatment of rheumatic fever and rheumatic heart disease. The Council is composed of representatives of national voluntary agencies concerned with work in the field of rheumatic fever.

EXPLODING A FALLACY

One of the fallacies of the modern amusement world that needs exploding is the too frequently portrayed myth about some poor suffering soul who agnoizes for days and years until someone can raise money to pay a famous specialist's fee.

In various forms, acquiring money for some unusual treatment, or operation, has been the theme for many a movie, radio program, Sunday comic strip and comic book.

I resent the implication that any person can't get the care of a top specialist in any field of medicine or surgery, if he seeks it. I resent the black eyes our fable writers give us in the minds of young readers. Let's get this kind of hog wash stopped. We aren't that kind of people!—C.P.P. in Bull. Columbus Acad. Med.

Sixty per cent of all children's operations are tonsillectomies—R. N.

BOOK REVIEWS

A TEXTBOOK OF GYNECOLOGY—By Arthur Hale Curtis, M. D., Emeritus Professor and Chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School, and John William Huffman, M. D., Associate Professor of Obstetrics and Gynecology, Northwestern Medical School. Sixth Edition. Pp. 799, with 466 illustrations, chiefly by Tom Jones, including 37 in color. Philadelphia and London: W. B. Saunders Co. 1950. Price $10.00.

The senior author's previous editions of this work have repeatedly been designed as a text book for students and a guide for clinicians. Since he has withdrawn from active university duties, the responsibility of the preparation of this text has been shared by one who is constantly in touch with gynecologic problems and progress.

There have been careful and extensive revisions of all chapters. As with the previous editions, there are many illustrations including thirty-seven in color.

The illustrations of the technical procedures are especially effective. Operative techniques can be clearly followed by this method.

In fact, the outstanding value of the book is the clarity of the presentation in text and drawings of the chosen operative procedures, the pathological studies and the charm of the authors' literary style. In this it is indeed a classic.

The authors' vast experience and decisive opinions are presented.

* * * *

SEX WITHOUT FEAR—By S. A. Lewin, M. D., and John Gilmore, Ph. D. Pp. 121. Lear Publishers, Medical Division, New York City. 1950. Price $3.00.

This is the latest addition to the long list of books of advice on sexual matters for the married and for those about to be. It is also one of the best. It is beautifully illustrated and printed, and is written in an easy, interesting style that is not without humor. The book is compact and complete, covering everything from anatomy to aphrodisiacs. Errors are few and not important. And furthermore, the authors do not try to go too far in their instructions. The reader is referred to the physician for further information, and the book is intended for distribution by physician's prescription.—David W. Northup, Ph. D.

MARYLAND MEDICAL MEETING IN SEPTEMBER

The semiannual meeting of the Medical and Chirurgical Faculty of the State of Maryland, will be held at the Vindobona Hotel, Braddock Heights, Frederick County, Thursday, September 28, 1950. The guest speaker at the scientific session will be Dr. A. McGehee Harvey, Professor of Medicine at Johns Hopkins University School of Medicine, Baltimore.

ANOTHER COMMITTEE NEEDED

There should be one more committee appointed in this Society—one to take care of the medical practice of the President while he is being President.—J. L. J. in Detroit Medical Journal.

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COUNTY SOCIETIES

CABELL

Dr. McLemore Birdsong, associate professor of pediatrics at the University of Virginia, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society held August 10, in the Fireside Room of the Hotel Frederick, in Huntington. His subject was "Surgical Conditions of the New Born," and his interesting discussion was illustrated by numerous lantern slides.

At the short business meeting following the scientific program, Dr. William Edward Bray, of the C. & O. Hospital, Huntington, was elected to membership in the Society.—James A. Heckman, M. D., Secretary.

* * * *

MINGO

A dinner meeting of the Mingo County Medical Society was held August 16, at the home of Dr. W. S. Feldman, in South Williamson, Kentucky.

The new AMA film, released to state medical associations for use by county medical societies, had its West Virginia local society premiere at this meeting. The doctors and their wives present were unanimous in their approval of the film, and many expressed themselves as holding to the belief that it should be seen by every doctor in the United States.

Dr. Innes Correll Hines, ortheopedic surgeon on the staff of the Williamson Memorial Hospital, was elected a member of the Society at a short business meeting following the scientific program.—E. T. Drake, M. D., Secretary.

COMMITTEE EXAMINATION IMPORTANT

Medicine has become specialized almost to the point of the right tonsil snatcher and the left tonsil snatcher of the old jokes. In the last few years there has been a definite trend back to doing general practice—at least more physicians admit that they examine the entire patient. No one of us can know everything even about one specialty, but we can examine every patient we see.—T. D. Young, M. D., in Texas St. J. Med.

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AFTER PEDIATRICS—GERIATRICS

That Gerontology and Geriatrics are more than passing fads of fancies in medicine is apparent to almost everyone from the fact that we now have an estimated 12,000,000 people living who are over 65 years of age.

During the first two decades of this century there was a slow rise in this group from less than 4% to about 5% of the total population. In the 1920s there was a rather marked increase. During that decade we saw insulin and liver extract begin to add years to our patients' lives.

In the latter part of the 1930s the added impact of chemotherapy contributed to a sharp increase noted by statisticians. The climb continues at a somewhat decreased rate in this present decade of antibiotics.

The projected rate for the last half of the present century predicts that between 12 and 15% of the total population will be 65 or over. With so many people living so much longer, where should the practice of geriatrics begin?

It has been said that middle age begins when you stop growing at both ends but continue to grow in the middle. Also, that an old man is anybody ten years older than yourself.

Recently a Public Health Authority was quoted by the public press as saying that our main concern in retirement programs should be to retire the old men of 40 and keep alive and active the young men of 60 or 70 and beyond.

All in all there does not seem to be much room to refute the statement that the practice of Geriatrics should begin where Pediatrics leaves off.—A. David Cloyd, M. D., in Nebrasca St. Med. J.

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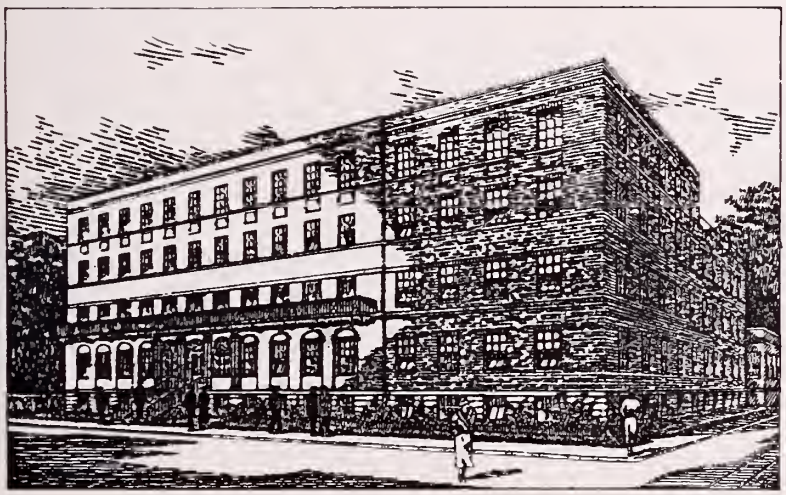

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VETERANS ADMINISTRATION
Regional Office
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Huntington, W. Va.

Mr. Charles Lively, Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia

My dear Mr. Lively:

In accordance with recent regulations, veterans who have an authorized major operation performed in a civilian hospital for a service-connected disability will be entitled to a total rating during their post-operative period in which it produces total incapacity preventing them to return to their previous employment.

This evaluation of convalescence during which the veteran is unable to work can cover any period not to exceed 90 days, following discharge from the hospital. It will therefore be necessary for the surgeons to notify the Regional Office of the Veterans Administration of their prognosis regarding the number of days that the veteran will be unable to return to work following discharge from the hospital. It will also be valuable to submit a report of the operative procedure as soon as feasible following the operation.

Where a veteran who has been discharged from military service for 36 months or more reports to a physician for what he believes to be an attack of malaria, and based upon the examination made, the attending physician is of the opinion that the veteran does have an attack of malaria, in connection with his report covering examination and diagnosis, it will be necessary for him to include a prepared slide of the veteran's blood smear and forward it to the Regional Office in a suitable container accompanying his report. This also applies to the treatment authorized for malaria by the Regional Office if the period is 36 months or more after discharge from military service.

It is important that physicians who are authorized to perform treatment on service-connected veterans submit their bills as close to the end of the month as possible or at the time of termination of treatment for the current month so that funds encumbered for surplus treatments can become available to authorize additional services to other veterans. This is due to the fact that our funds are limited and must be kept as fluent as possible. It is therefore also necessary that physicians keep their requests for services limited to the actual number of treatments that will be required and not ask for an excessive amount which will not be utilized.

Some difficulty is being experienced in the submission of Form 10-2690, which is a request for continuation of treatment, in that they are not being forwarded before the beginning of the succeeding month so that the services can be set up and authorized in

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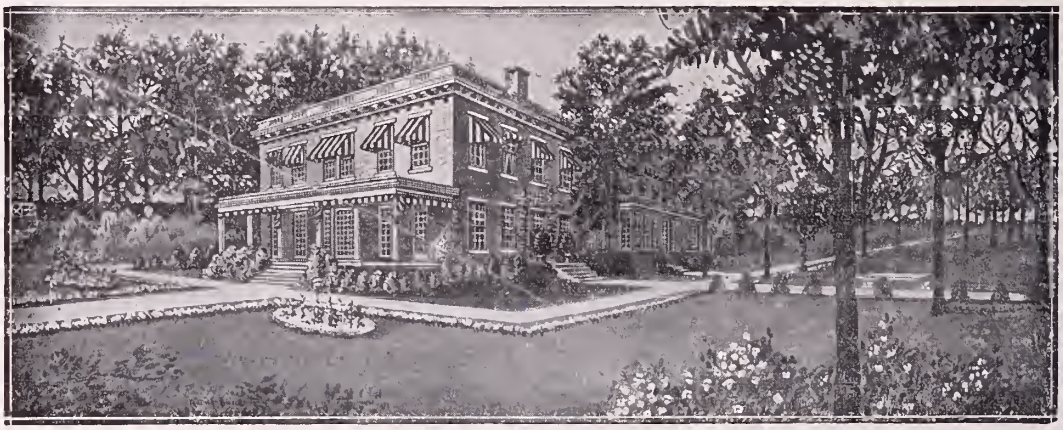

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advance for the following month. This has resulted in instances in which physicians have initiated further treatment before the request had been received and could be authorized and resulted in the loss of payment to the physicians.

It is the intention of the Veterans Administration to reimburse for all services performed, but it is important that the physicians cooperate and submit their requests sufficiently in advance so that periods of treatment can be covered.

Very sincerely yours,

Leo F. Steindler, M. D.,
Chief Medical Officer.

* * * *

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Aug. 12, 1950

Mr. Charles Lively, Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia

Dear Mr. Lively:

This school is looking for candidates for fellowships in occupational health (industrial medicine). Certain of the appointments can be given to men who have completed rotating internships and who have been in general practice for less than ten years. The training will cover a two-year period and is considered ade-

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Sincerely yours,

(Signed) A. G. Kammer, M. D.

AGK/dv

REAL ISSUE IS SOCIALISM

One-third of our national production and income has been socialized by taxation, one-third by bureaucratic orders, licenses, price fixing subsidies and outright controls. Less than one-third of our economy is free. We have already gone too far, and the job before us is staggering, but let's get going. The real issue is Socialism.—J. Mich. St. Med. Soc.

RESEARCH FELLOWSHIP IN ARTHRITIS

The Arthritis and Rheumatism Foundation is offering fellowships for research in the basic sciences related to the study of arthritis. The fellowships, which are for a period of one year, carry a stipend of from $4,000 to $6,000 depending upon the needs and ability of the worker. They would begin in July, 1951, although earlier appointments will be considered by the committee.

Applications should be mailed to the Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, New York, not later than January 1, 1951. Notification of fellowships granted will be made public March 1, 1951.

MISS WOODDELL ON TB PROGRAM

The 36th annual meeting of the Southern Tuberculosis Conference comprising 15 states and the District of Columbia will be held at the Roanoke Hotel, in Roanoke, Virginia, September 21-23, 1950.

Miss Martha Wooddell, R. N., of Clarksburg, executive secretary of the Harrison County Tuberculosis Association, will preside at a meeting of the public health section, scheduled for Thursday afternoon, September 21.

The theme of the conference will be, "The Crisis: The Non-Hospitalized Patient."

Primary bronchogenic carcinoma is second, and almost equal in its incidence, to carcinoma of the stomach. —J. F. in Ohio State Med. J.

CHESTNUT LODGE ROCKVILLE, MARYLAND

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REASON FOR URBAN TREND

There are good reasons why doctors are not locating at the crossroads in rural communities as they did 50 years ago. Before the turn of the century the country doctor could make a living on typhoid fever, diphtheria, pneumonia and summer complaints. Immunity measures provided by medical discoveries have virtually eliminated typhoid and diphtheria. Sulfonamides, penicillin and aureomycin and other new drugs, have rendered pneumonia much less ominous for the patient and much less profitable to the doctor. Refrigeration, sanitation, and improved medication have almost eliminated summer complaints.

Improved roads, automobiles, and transportation by air, plus education with reference to clinics and hospitalization, tend to whisk the patient by the country doctor while he is being penalized by the new medical publicity and motorized psychology.

Considering modern transportation, the country patient 50 to 100 miles from the nearest city relatively speaking is much closer to medical care than the patient living 10 miles from his country doctor fifty years ago. Under these circumstances, it is hardly fair to expect the well trained young doctor to invest 30 to 50 thousand dollars for sufficient modern facilities to stop the motored marathon toward city doctors.

Are the people and the trend of the times to blame or must the medical profession be held responsible for the dearth of country doctors?—Lewis J. Moorman, M. D., in J. Oklahoma St. Med. Assn.

SLIGHTLY EMBARRASSING

Just the other day, Oscar Ewing, the federal security administrator, found himself obliged to announce that the infant mortality rate had dropped to an all time low in 1948, when only 32 of every 1,000 babies died during their first year. The rate in 1930 was 64.6, and in 1940 it was 47. With only half as many dying in 1948 as in 1930, it is predicted that compilation of the statistics for 1949 will show even greater reduction.

A second announcement within two days from government offices provided further significant evidence of the quality of medical care available to the American public. The United States Public Health Service reported that the average life span for men and women, based on 1948 death rates, is at a record high. For white women it is 71 years and for white men, 65.5; for nonwhites it is 62.5 for women and 58.1 for men.

It was only a month or two ago that the office of vital statistics reported the average life span of all Americans as 67.2 years, another record. Furthermore, about the same time Mr. Ewing was required to report that the progress of medical science in the fight against communicable disease has brought the nation's death rate to the lowest point in history, 9.9 for each 1,000 population.

Surely it is passing strange to find Mr. Ewing and the agencies he directs reporting so optimistically on these health problems and telling the American people how hale they remain after entering the ranks of the elderly—J. Fla. Med. Assn.

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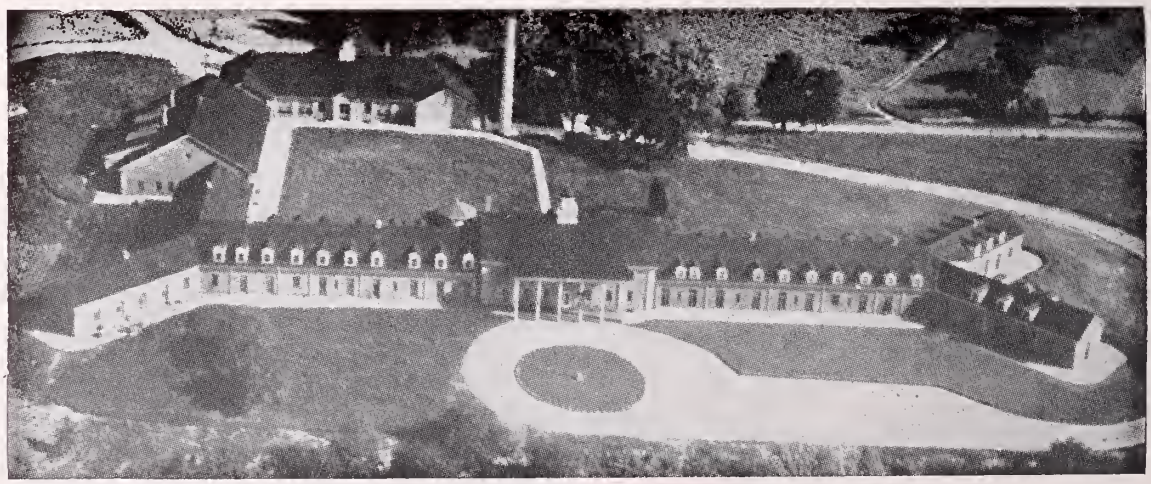

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PARANOID REACTION IN THE AGING

After a persons passes 60, he more or less gradually approaches what is commonly called his "second childhood." He again shows many of the behavior characteristics of his early youth. Stieglitz has questioned whether this may not be truly a reappearance of the suppressed behavior of one's primal childhood. Many of the same characteristics are present, the self-centeredness, selfishness, and limited interest in others. During middle years, although competition is a necessary part of business or professional life nevertheless children, other dependents, and charities demand our attention and necessitate a varying degree of altruism. Desires for individual gratification are less apparent or usually less possible of fulfillment.

When instinctive drives find adequate outlets, contentment ensues and relatively little tension arises. But, when these drives are checked, tensions mount, expressed in feelings of anger, irritability, fear, apprehension, suspicion, and self-pity. Psychological defense mechanisms develop to lessen the tension and discomfort.

In the aging, the two most common defense mechanisms are depressive states and paranoid reactions. Such mechanisms, while they seem inconsistent and frequently incomprehensible to others, do afford the persons in whom they develop a certain amount of compensation and often appear to prevent further or more complete personality disintegration. They serve as a means for objectifying aggression. In depressive states the aggression is turned inward on the person depressed, while in paranoid reactions it is directed outward toward others.—Ed. B. Allen, M. D., and Hollis B. Clow, M. D., in Geriatrics.

WHAT NEXT?

The why, how and where of ACTH and Cortisone cannot be dismissed too lightlyy. These are academic questions but they have an important bearing on the cause and treatment of disease. The compounds have produced amazing results in many instances making it possible to turn on and off many diseases at will. The arthritic, for example, is relieved of his symtoms but is left with diabetes unless the dose is controlled. On the other hand when the drugs are withheld, the blood sugar and urine return to normal but the arthritis reappears. A tuberculous patient who received ACTH showed signs of improvement within seventy-two hours. The fever began to subside, the sedimentation rate dropped and his appetite improved. In time all signs of the disease disappeared with the exception of the sputum, which remained positive. He was well but still infectious.

These phenomena were unheard of two years ago. They are food for thought and may change our concepts of disease and treatment. In the future, the etiology may lose its importance from the therapeutic standpoint; the problem will be tackled by nullifying the reaction of the body to this unfavorable agent. —Illinois Medical Journall.

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EDUCATION IN POLIO FIGHT

People have a unique dread of poliomyelitis, largely based on the inborn fear of the unknown. Its etiology is unkown. The onset is dramatic and unheralded, and the outcome is unpredictable. Its effects are often irreversible. This attitude held by the public must be met by a forthright management of the problem in the light of present knowledge of poliomyelitis, limited as it is. When possible, the public-health officer should serve as the source of education for the physician as well as the laity. In this education the aim should be accuracy of information and relief of fear and anxiety.

Latest data on poliomyelitis should be possessed by the doctor before the public receives similar information from the press, radio, clubs and television. Citizen committees to meet the peculiar needs of an afflicted community may work with personnel of the medical profession to accomplish much during an epidemic.

The public should know that of 100 exposed persons, symptom free but harboring the virus, actually only one suffers a clinical attack. Also, of those exhibiting clinical manifestations of the disease, only a small percentage are left with crippling sequelae. Education in the care of patients in the preparalytic stage will not stop an epidemic once begun, but may prevent paralysis.—Ellen Vogel in New England Journal of Medicine.

WILL MEDICINE NEED A LANGUAGE?

Medical language reflects its long history. Necessarily it has had to be compounded of Latin and Greek terms to which have been added in the course of time accretions from other sources. More recently have come the trade names of many articles, biologicals, synthetic products, and a rather loose use of the English language which does not always convey to a listener what the speaker intends to transmit.

The net result is that the doctors may be and frequently are charged with the use of "medical jargon." Many non-medical people think that this is intentional which, of course, in most instances is far from the fact. Nevertheless, it is forseen that somehow a simplification of expression will have to be worked out, probably based on the plane of the "comics" or the language content of the "movies" and, more recently, the video programs.

If some solution of the problem is not arrived at, the day may soon come when, on the basis of its alleged jargon or jabberwocky, the medical profession may be adjudged to be "high hat" and come eventually to be classed with the professional politicians whose "gobbledygook" has set them latterly, in the seats of the mighty, sematologically speaking. This would be unfortunate. Because doctors by and large are plain working people and should have available a plain working language in which to speak to the folks.—Westchester Medical Bulletin.

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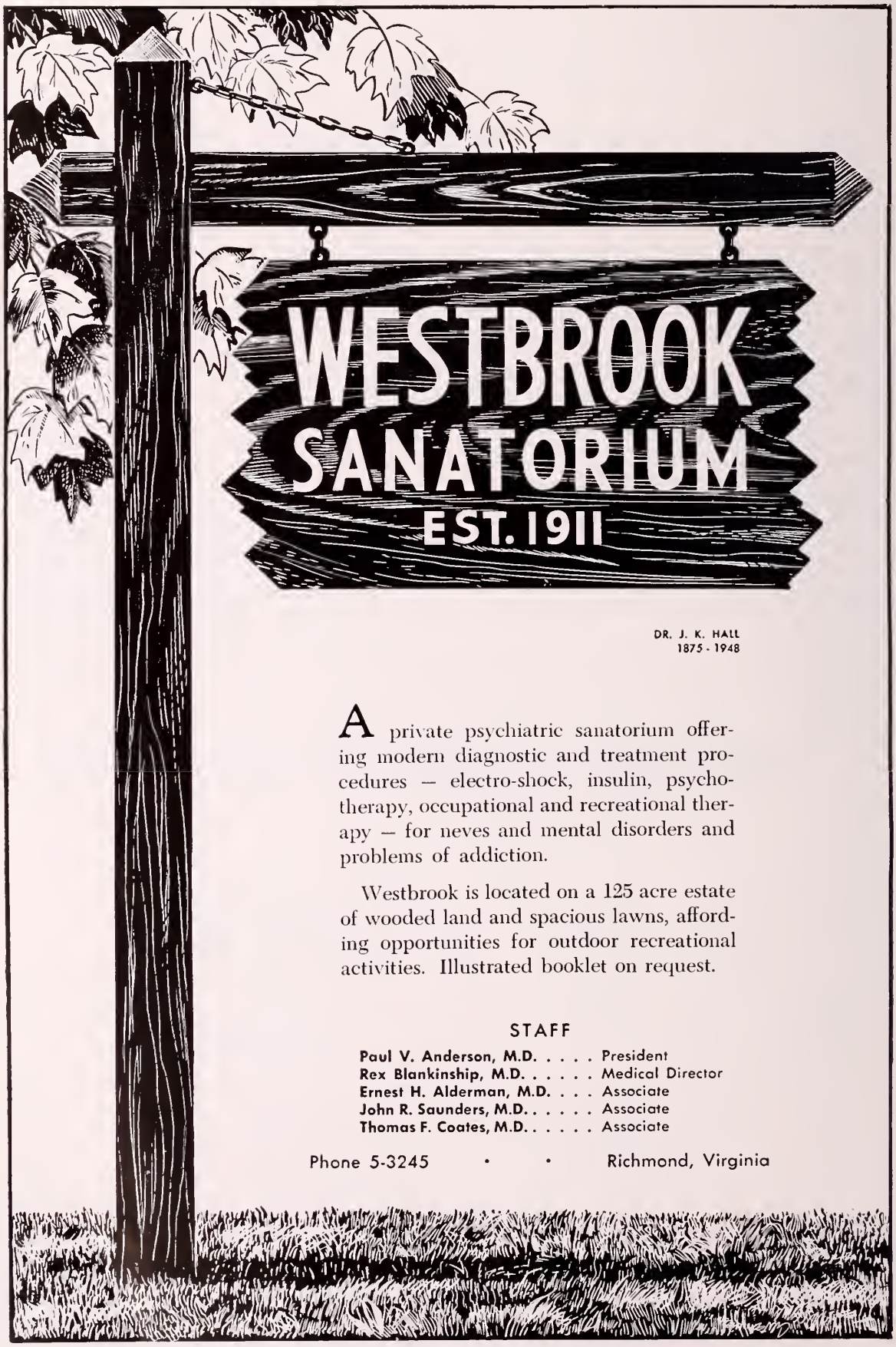

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Editor
WALTER E. VEST, M. D.
955 Fourth Ave.
Huntington, W. Va.

Managing Editor and
Business Manager
MR. CHARLES LIVELY
Box 1031
Charleston 24, W. Va.

Associate Editors:
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MEDICAL FREEDOM AND HOW TO KEEP IT*

By LEONE BAXTER,
Chicago, Illinois

Undoubtedly you gentlemen have heard how one sweet young thing described her wealthy admirer, when pressed by her girl friend to know just what type he was. "Well," she said, "he thinks of himself as a wolf; but I think of him as a mink!"

Obviously the young lady was unaware that with wolf or mink the principle of the thing is somewhat the same: Generally speaking, a giver of gifts, a bestower of blandishments, seems to expect some favor or other in return. And, speaking very frankly, a wolf whistle from Washington involves the same principle as one from any other quarter.

When you gentlemen here, and the doctors of the rest of America, decided 18 months ago to launch your campaign against government medicine, you knew that government, too, can be a giver of lavish gifts — with a string attached.

But at that time, millions of Americans had been educated for years to the supposition that government is a free supplier of money in unending amounts, of services at little or no cost, a benefactor who asks nothing in return.

You knew otherwise. You knew what the cost of government Compulsory Health Insurance would be in sub-standard medical care, in wasted public money, in loss of individual freedom, and in transfer of local determination for politically centralized power. You knew the greatest cost would not be to the medical profession, but to the American people as a whole.

You knew that irrespective of any good intentions involved, Compulsory Health Insurance would be used by some sources as a starting point for a drive to crush free institutions and voluntary action in other professions and businesses and industries.

You launched a campaign based on a conception which seemed fairly new to a lot of people, the simple conception that if the plain facts, the irrefutable truth, could be placed in the hands of enough people, so that they could recognize it as their own, poignant story, not somebody else's battle, the people of the country could be depended upon for a sound answer. You were willing to stand or fall on that answer.

Considering the situation at that time, many reasonable people thought you were foolhardy even to try to turn the tide so strong against you. A minority of doctors themselves thought it was a perfectly hopeless gesture, and said so publicly. You were in the position of the hard-pressed bridge player who bids a grand slam, knowing he'll make it, if he can just finesse three times.

The country had been harangued for a very long time on the advantages of Compulsory Health Insurance. A great deal of public money had been spent to create a picture of the inadequacies of the American medical system. A contrived campaign to discredit the profession had been in progress for many months. It was reaching its peak in a series of medical society investigations at that moment. Legislation was pending in Congress which would regiment the

*Presented before the 83rd Annual Meeting of the West Virginia State Medical Association, at White Sulphur Springs, July 27, 1950.

medical profession, and destroy the American Medical system as we know it.

In addition to all that, you stood quite alone when you said, "For medicine and for America, we are going to make this fight."

Since that day, you've made your three finesses, and many more.

The state of your health as of now, politically and professionally speaking, is most significantly described by those who didn't give you a chance for recovery when the socialized medicine malady first hit you hard 18 months ago. For example, among the strongest and most outspoken leaders in the opposition camp was the St. Louis Post Dispatch. But recently, it said in a long article describing the doctor's compaign: "Today, collectively and individually, they (the doctors) are a political force to be reckoned with."

Political eminence certainly is not what doctors set out to win. But it appears that by virtue of the results accomplished, you have so distinguished yourselves. And at this particular time, we are not, of course, unmindful of the value of such a reputation.

In any case, the medical profession has earned high respect in the field of politics, or more exactly, public affairs. How did you acquire it? I'd be carrying coals to Newcastle to discuss it here in West Virginia.

Doctors everywhere in the nation accepted very quickly the campaign strategy. Doctors everywhere sensed the need to solve problems of medical care, medical cost, medical service. They understood that much of the National Education Campaign's success depended on the confidence, the esteem, the trust of the general public in the profession.

More than some other areas, you here in West Virginia sensed those things keenly. And nothing in the National Education Campaign has given more joy to the Coordinating Committee or to Whitaker & Baxter than the proof established here that the majority of the people of your state have a healthy distaste for compulsion, a friendly respect for West Virginia's medical fraternity, and that they generally believe in what you are trying to do, and want to try to help you to do it.

Along with every other state, you started from scratch, and today you have over 812 responsible organizations standing with you on the issue of Voluntary versus Compulsory Health Insurance.

You have told your story so well that today, though West Virginia is certainly not the largest state, nor has it the greatest population, you have more organizations standing on formal public record with you than any other state in the Union except one, Indiana.

You men here, as medical leaders, have the congratulations of the National Committee and of the Board of Trustees of the American Medical Association, and the deep appreciation of Whitaker & Baxter.

The example set here actually has been an inspiration to other states. And at this time I should like personally to pin a verbal rose on the magician in your midst, your public relations chairman, Dr. Frank J. Holroyd. I'd like to pin another one on a gentleman who has aided immeasurably in the National Campaign, your Executive Secretary, Mr. Charles Lively.

I'd like to go down the list and name all the West Virginia leaders who have given so generously of their time and efforts, but I have an idea you revere and appreciate them without any comments from the outside. But I should like to say that your Journal has done extremely helpful work, and that one of the best performances in the whole National Campaign has been turned in by your own West Virginia Woman's Auxiliary.

Dr. Christopher Daniels, of London, visiting here recently, said in relation to the situation in his home country: "Socialism is like polio. You do not know when you catch the disease, and when, and if, you recover, you have a lame leg."

We believe that the people of this country have recognized the seeds of socialism in the plan proposed by the Federal Security Agency, and they feel such a plan would leave the Voluntary system with a lame leg, that is, seriously impaired.

We believe, frankly, that that is why we have been able to amass on this issue a people's mandate far beyond anything the advocates of socialized medicine might conceive in their most pessimistic moments. Actually, medicine today has the support of over 10,000 great, non-political organizations. That is the greatest cross-section of public sentiment ever formally amassed on a controversial issue in the nation. It didn't come easily. It didn't come expensively.

What are we going to do to maintain and preserve that amazing support which we have labored so hard to earn? Those who advocate Compulsory Health Insurance are politically shrewd. They won't permit a roll call in Congress in this session. We must find other means of solidifying medicine's position. We have found such means. We have a plan. We'd prefer a congressional vote. But, denied that, we shall try through a carefully-planned advertising project

to crystallize public sentiment into public conviction.

The project has been studied with great care and approved by the AMA Campaign Committee, the Board of Trustees, and the House of Delegates. It has been reported widely in the press as a million-dollar campaign. Its details, its objectives, its cost, are no secret.

I believe I said recently in Washington, in reference to our procedure of outlining campaign plans freely and fully for friend and foe alike, that similar to a French bathing suit, the device should be used only by those with nothing to conceal. Medicine has nothing to conceal.

We have been at work for some time preparing copy for use in every bona fide daily and weekly newspaper in the country, for 35 National magazines of general circulation, for 353 radio stations. The copy will be designed simply to show how the people of America stand on the issue of Compulsory Health Insurance versus Voluntary Health Insurance.

The ads will go out, by the way, in plenty of time to permit Mr. Ewing's office to answer, if they so choose, and long before election time. We understand proponents of Compulsory Health Insurance are very much worried on that point.

What can we prove by such action? We believe we can prove that if a general election were called on the issue of Compulsory Health Insurance, the people would vote "no." We think that will be valuable information at this time for many people.

We believe we can prove that among the majority of Americans Compulsory Health Insurance has been discredited by the facts and that Voluntary Health Insurance is more firmly established every day.

We believe we can prove the growing confidence of the public in the medical profession, and in its sure, steady progress toward the goals in medical care, and service which the people want.

For its sustained effect on future events that may concern the profession, and thus the health of the nation, we believe that the respect and esteem medicine has won needs to be pointed out for the record in every community of the Nation. That's why we choose to use, in addition to the metropolitan press, the home town "Grass Roots" papers irrespective of size, location or editorial position.

In the battle to preserve medical freedom, the two most important tools are, first, the vastly expanded constructive work which doctors are doing to solve both medical problems and problems of medical economics. And, second, your new allies. They are implements of great interdependence. You can't maintain the latter, unless you maintain the former.

After such a climax, even without the conclusiveness of a congressional vote on the issue, we believe medicine can taper off its campaign and not be under the necessity for an exhaustive fight for survival such as you have sustained for the past eighteen months.

The theme of the advertising plan is simply, "The Voluntary Way is the American Way."

It will interest you to know that other professions, businesses, and industries are indicating daily that they want to participate in what they consider a crusade of freedom. They want to show their recognition of the service medicine's campaign has been to the nation. They want to testify publicly as to where they stand. Medicine's own advertising project unquestionably will be doubled and possibly trebled by sources outside medicine. We are frankly inviting such participation by everybody who believes in the way of life your campaign has epitomized.

I believe that the convictions of people in the "Grass Roots" of this country are well expressed by the comment of the Doctor, speaking right here in West Virginia, who said that "medical services should be built from the community up, not from Washington down."

The new allies of medicine have placed themselves in your company in the fight for freedom because they know you can't retire from the Voluntary field if you want Democracy to survive, for Democracy is built on Voluntary action. I believe Americans are learning that a guaranteed life is not a free life.

You, in eighteen months, have helped America to recognize that fundamental, more clearly than it has been seen in this entire generation. For the sake of the nation we love, we must hope that the recognition will last, and the vision endure.

It has been our pleasure in this campaign to have a part in helping to build for medicine as sound a structure in its public relations as medicine has built for itself in the field of its own science. Much of that pleasure has been in the challenge of doing a worthwhile job.

Most of it, gentlemen, has been in sharing that challenge with people like you here in West Virginia.

Tuberculosis rates . . . rose in every European country seriously affected by the war, and there is a growing realization that tuberculosis is our main public health problem.—Marc Daniels in Brit. M. J.

THE BROADENING FRONT AGAINST STATE SOCIALISM*

By CLEM WHITAKER
Chicago, Illinois

Miss Baxter and I are very happy to be here today because we are exceedingly proud of the splendid work you have done in West Virginia.

We are grateful to have had the opportunity to represent you and your profession in a crusade which we believe will alter the course of history in our country—and alter it all for the better!

The doctors of this country can be very prideful citizens for what they have accomplished in stopping the inroads of State Socialism in America.

I think you should know, too, that in the offices of A.M.A., and in our National Campaign Headquarters, the West Virginia State Medical Association is on the honor roll as one of the finest, *fightingest* medical societies in the United States.

The public support for medicine's cause which has been won in this State is a wonderful tribute to the leadership which this House of Delegates has provided, and is eloquent evidence that you are willing to fight and work to maintain your freedom.

It is a very satisfying experience to fight for a cause that is right, and for men and women who have the courage of their American convictions.

During the past year and a half, Miss Baxter and I have experienced that deep satisfaction, and we are grateful and proud to be your representatives.

We not only believe in your principles; we respect you for the way you fight for your principles.

What is more important, your political opponents now respect you, too!

The political demagogues in Washington who deliberately set out to discredit American medicine, and then to seize control over it, got the shock of their lives when doctors, instead of backing away from the battle, met them before the American people in open contest and made them give ground. The impact of that shock even rocked The White House. Even though their designs may be unchanged, never again will your opponents under-estimate you. Never again will they make the mistake of considering the medical profession a popular and defenseless "whipping boy"!

You can be very proud of that accomplishment because you have proved that you not only believe in medical freedom, but that you are able and willing to defend it.

A doctor acquaintance of ours, who has worked tirelessly and most effectively in medicine's campaign of education, came into our Chicago office recently to tell us this interesting story.

"At the beginning of the campaign," he said, "I hated Oscar Ewing with a fierce hatred for making me take so much time away from my practice, and for costing me so many evenings and Saturdays and Sundays which I would have preferred to spend with my family and friends. But, I feel very different about it now. I can almost develop a kindly feeling for Oscar Ewing, because unintentionally he has made me a better doctor and a better American.

"Except for a few personal friends," he explained, "I used to come in contact only with the sick, and humanity, as I knew it, was pretty sick. Now I know how healthy, normal people think and act. I've learned to know something about the problems of my community and my country, too, wholly apart from medical problems, and I am a better doctor and a better citizen as a result of the experience."

That simple testimonial from a doctor on the firing line was very reassuring to Miss Baxter and me, because we know the great sacrifices in time and income and loss of leisure which this extra burden of work has cost the thousands of doctors who have carried the brunt of the battle.

I hope that many of you, too, have found real satisfaction and unexpected compensations in this fight for freedom, and I am sure you have.

Dr. Elmer L. Henderson, the new president of your American Medical Association, is here today and will address you this evening. The sacrifices he has made during the past year and a half, as chairman of the Campaign Coordinating Committee, have been very great. No one knows that better, perhaps, than Whitaker & Baxter, because we have worked with him almost daily and we have been glad in our hearts that when medicine came under attack it had men of his courage and patience and stature in positions of leadership.

I think it is good that you know that you have men of great heart and tireless energy leading your A.M.A. at this time. I hope you know the great respect which they have won in Washington and the great esteem in which the whole medical profession is now held by all who are devoted to maintaining our American freedom.

You have men like that here in West Virginia, too, men whose medical practices have suffered,

*Presented before the 83rd Annual Meeting of the West Virginia State Medical Association, at White Sulphur Springs, July 27, 1950.

whose personal lives have almost been forgotten so that they might help to guarantee that every doctor can walk and work in dignity and pride as a member of a free profession.

All of you, undoubtedly, have felt the strain of this fight for survival, and I think today we should take a look at the credit and debit side of the ledger and see what we have attained.

Dr. Henderson stated it very eloquently when he declared: "American medicine has come a long way in a short time!"

A year and a half ago, American medicine was almost entirely bereft of allies in its fight for freedom.

A year and a half ago, we feared a roll call on this issue in Congress.

A year and a half ago, Congressional mail was running nearly 2½ to 1 in favor of Compulsory Health Insurance.

A year and a half ago, Senator Pepper was busily and bitterly berating American medicine on the floor of the United States Senate with no fear of the consequences.

A year and a half ago, American medicine was on the defensive, with its back to the wall, fighting for its very existence.

Today, we have a magnificent army of allies, with more than 10,000 great public organizations, standing beside medicine and looking to the doctors of America for leadership in the broadening battle against State Socialism.

Today, we are ready for a roll call in Congress, and it is the socializers now who are anxious to avoid a showdown on this issue.

Today, the people of America know the facts, and the mail received by the members of Congress is running 3 to 1 against socialized medicine.

Today, Senator Pepper, one of medicine's most violent critics, is a "lame duck" Senator, about to go into involuntary retirement. He chose to stand or fall on the issue of socialized medicine before Florida voters, and the crash of his fall is still resounding in Washington.

Today, American medicine is proudly on the offensive, fighting not only for freedom in medical practice, but for the free way of life that is the foundation of our Nation.

Today, your profession has become the inspiration of other professions and businesses and industries, and millions of individuals have found new courage and new hope to bulwark them in their own struggle against regimentation and government-domination of their affairs.

There are many reasons for this great transformation. Until the issue was drawn, only a few hundred doctors, or at the most, a few thousand, were actively at work, trying to counteract the constant stream of propaganda for socialization which flows from the Federal Security Agency and other departments of the government.

But by the end of last year, 50,000 individual doctors had enlisted in medicine's campaign—and now that number has risen to more than 90,000 doctors who are actively and aggressively engaged in the job of public education on this issue.

We are not speaking now of passive cooperation, because at least 98 per cent of the medical profession in the United States is opposed to socialized medicine and is sympathetic to the profession's campaign.

But 90,000 doctors, according to the records in our offices, are actively at work on this issue, talking to their patients, distributing pamphlets to their friends, giving speeches before their civic groups, writing to their congressmen and contributing in every way they know how to the tremendous task of informing 150 million Americans on this issue.

Doctors and their wives (and in many instances, I think the members of the Auxiliary are doing even a better job than their husbands) have distributed 100 million campaign pamphlets and leaflets on this issue in less than 18 months. That is mass education on a scale never equalled in this country, except during a presidential campaign.

They have delivered more than 25,000 speeches at gatherings ranging from small farm bureau sessions and neighborhood forums to huge city mass meetings.

They have sent tens of thousands of personal letters and telegrams to their representatives in the two houses of Congress.

They have talked, personally, to millions of individual citizens, to their friends, their neighbors and tradesmen, the members of their churches and their community organizations.

And since doctors set about earnestly practicing on the body politic, they have been joined by nearly a quarter of a million additional crusaders in allied professions and trades and in supporting organizations. As a consequence, American medicine today has become a mighty force in the battle to save America.

It was Daniel Webster who said, "God grants liberty only to those who love it, and are always willing to guard and defend it."

You have demonstrated, in wonderful fashion, that you are able and willing to fight not only for freedom in medicine, but for freedom for all your fellow Americans. The fight is far from won, because the threat of State Socialism still hangs over the whole Nation, and millions of men and women in other countries have lost every right that is important to free people.

In international affairs, as well as our domestic affairs, this is a very critical period for America. At this very moment, American boys are fighting and dying in a war against communism in Korea. We are all acutely conscious that the present conflict in Korea may explode into World War III any day, and Congress already has started to take steps to put this nation on a war footing.

We are not a militaristic nation and no real American wants war. But if that war should come, no one in this room would even hesitate in deciding where his allegiance belonged.

We have a pride in America that goes far beyond normal love of country. Our love of country is fortified by our love of individual independence, and we have valued our birthright of freedom more highly than any other possession.

But, while we are alert to the threats abroad, while we are keenly aware of the rising power of Soviet Russia, and the fearful possibilities of an atomic war, many of the American people have not yet recognized the immediate and critical threat to our freedom which exists here at home, where we have an undeclared war, an economic civil war and a war of clashing ideologies which could utterly destroy America as we know it, without a single bomb being dropped, and without any foreign aggressor being directly involved.

There is a desparate struggle now in progress which you, as doctors, recognize because you were among the first to be attacked. This is a drive to centralize all power in Washington, to make the American people walk in lock-step, and to substitute State Socialism for Americanism.

The danger in this type of war is that it isn't recognized as such. It lacks the dramatic impact of a war with guns. It is a war of attrition, a gradual wearing down of public resistance to government-encroachment on the rights, liberties and properties of individuals.

All over America, doctors have carried the issue of socialized medicine and the broad issue of State Socialism directly to the people, and already there has been spectacular evidence that this issue will be fought out at the polls in Congressional elections throughout the nation. This is the American way to cope with an attack on fundamental American liberties, and the people of this country can be depended upon to hand down an unmistakable mandate on this issue, if the facts are properly presented to them.

No matter how great the threat from outside aggressors may be, we cannot, we must not lose this war to maintain our independence at home, because if we should lose, Russia would have won, just as surely as if Communist troops had over-run our country.

Dr. Henderson, your A.M.A. president, defined the issue in his inaugural address when he declared, "There is only one real difference between State Socialism and Communism. Under State Socialism, human dignity and human liberty die a little more slowly, but they die just as surely."

This is the fight which American medicine is leading, a challenging fight to preserve our basic freedoms, a fight against wilful, ruthless men in our own government who would make economic drug addicts of the American people, so that they could exercise power over them.

If the doctors of this country, and their loyal allies, continue to love liberty, and to guard and defend it, you can be very confident of this: American medicine will win its fight for freedom. More than that, it may well become the deciding force in saving this country from the disaster and degradation of State Socialism.

Then, as you watch young men coming into your profession, you can say to yourself: "Thank God, they can practice in freedom." And you can be proud that you played a part in defending their American birthright of freedom.

This crusade in which medicine is engaged isn't just an extra burden that has been given you. This is the greatest opportunity any of us has ever had to render a great service to our country and to all humanity. This is our chance to preserve the great heritage that has been given us.

"FIRSTS" FOR CORTISONE AND ACTH

Cortisone and ACTH can already be credited with an impressive number of "firsts." They are the first natural agents by which has been demonstrated the potential reversibility of several diseases, including especially rheumatoid arthritis. They are the first agents which have shown real promise of affecting certain features of acute rheumatic fever and acute rheumatic carditis which have not heretofore been influenced by salicylates. They are the first natural or hormonal agents found capable of giving consistently symptomatic relief and a temporary reprieve in the face of an intercurrent severe acute crisis of disseminated lupus erythematosus.—Philip S. Hench, M. D., in Proceedings of the Staff Meetings of the Mayo Clinic.

RETROBULBAR INJECTION OF ALCOHOL*

By CHARLES M. POLAN, M. D.,
Huntington, West Virginia

My interest in retrobulbar injection of alcohol first was aroused in the fall of 1944 while awaiting overseas shipment at an aerial port of embarkation. The ophthalmologist at the station hospital called me in to see a severely wounded soldier who had just arrived from the European theater by air evacuation. The man had received severe injuries including traumatism of one eye. He stated that he had been injured by shrapnel, and that during the course of treatment a retrobulbar injection of alcohol had been given.

The eye was severely inflamed and blind. We could hardly believe that such treatment had been used. We checked the patient's field medical record and found an entry describing the procedure. We decided that whoever had given the injection must have been out of his mind as neither of us had ever heard of such treatment, nor could we find any reference to it in available source material.

My next knowledge of the procedure was gained in reading an abstract of an article from the Spanish literature in the abstract section of the American Journal of Ophthalmology a few months later.

I have discussed the use of retrobulbar alcohol injection with friends and acquaintances at different meetings since I returned to this country and have found a growing knowledge and use of it.

There has been little written about this procedure in the American literature. I have checked several of the standard texts on ophthalmology as well as books on ocular therapeutics and have found only one brief description of this procedure.[1] The first article that I have seen was by Maumenee and appeared in an issue of the American Journal of Ophthalmology.[2] I shall summarize that article briefly and report 4 cases in my own experience in the use of this treatment.

Maumenee's article reported the use of retrobulbar injection of alcohol for the relief of prolonged severe ocular pain in 41 blind eyes and 15 eyes with vision, all treated between 1942 and 1948.

"The treatment of prolonged severe ocular pain is one of the most trying problems in ophthalmology. Frequently partially seeing eyes and blind eyes which are not disfiguring or otherwise dangerous are removed because the patients can no longer tolerate the pain caused by them. In many instances these patients can be relieved of the pain for several months, or even longer, by the use of retrobulbar alcohol injections. If, during this interval, the cause of the pain is alleviated, the eyes might be saved and useful vision retained. Retrobulbar alcohol injections should, therefore, have a definite place in the armamentarium of ophthalmic therapy."[2]

The technic described was similar to that used by various European observers. The patient is requested to look up and nasally, and a 3.5 cm. 22 gauge needle is inserted into the lateral third of the lower lid just above the rim of the orbit. The needle is passed through Tenon's capsule between the lateral and inferior rectus muscle into the muscle cone. The plunger of the syringe is withdrawn slightly to make sure a blood vessel has not been entered. One cc. of 2 per cent novocaine is injected and a few minutes later 1 cc. of ethyl alcohol is injected into the orbit. Patients frequently complain of pain in the orbit and dull headache.

Shortly after the injection, chemosis of the conjunctiva and proptosis of the globe may develop. This may last a day or more. Partial paralysis of one or more extra-ocular muscles may result, but this complication usually disappears in a month or two. Patients frequently complain of a feeling of fullness in the orbit for a short time, but when the injection has been given properly the ocular pain is relieved. If the procedure has been unsuccessful for one reason or another, the injection can be repeated 2 or 3 days later without danger.

At Wilmer Institute the use of this procedure was approached cautiously. It was used at first for blind eyes only, and 1 cc. of 40 to 50 per cent ethyl alcohol was injected into the muscle cone. Pain was not always controlled by this strength of alcohol and as the complications were neither severe nor permanent, 95 per cent alcohol was tried. The results were found to be more consistent when the stronger solution was injected, and during the last half of the period covered by Maumenee's report 80 to 95 per cent alcohol was used.

Fifteen eyes in the series of cases reported were later enucleated. Histologic examination of those eyes failed to reveal any evidence of injury to the optic nerve. In some cases there was slight cellular infiltration of the posterior sclera. The only instance of injury of the optic nerve that Maumenee could find in the literature was that reported by Cordes (Am. J. Oph. 12:120, 1929). In this particular case the optic nerve was injected when an attempt was made to inject the

*Presented at the staff meeting, Huntington Memorial Hospital, Huntington, W. Va., December 15, 1949.

sphenopalatine ganglion. The patient saw a sudden flash of light during the injection, and suffered permanent total loss of vision. Paralysis of the extra-ocular muscles developed, also ptosis. The optic nerve became atrophic but the motor function of the muscles returned.

Maumenee's report confirms my own experience and impressions gained in the use of this procedure. I have been very cautious in deciding to use a retrobulbar alcohol injection and have reserved it for eyes that have been extremely painful and for use when enucleation was refused, or when I was trying to avoid enucleation of the offending eye.

Case 1.—The first patient in whom I used a retrobulbar alcohol injection was Mrs. H. W., a 63 year old white female, who was admitted to the Huntington Memorial Hospital February 5, 1949, complaining of pain in both eyes and blindness of 4 days' duration. The history revealed that she had had glaucoma for three years. The right eye had been blind for nearly three years. Examination of the eyes showed absolute glaucoma in the right eye and acute glaucoma in the left eye. The right eye was blind and vision in the left eye was reduced to light perception. The tension in the right eye was 66 and in the left 55 (Schiotz). She was treated with miotics and morphine for the pain. The tension did not decrease on this regimen over a period of three days. The patient finally agreed to have surgery as the pain in both eyes continued to be extremely severe. On February 8, 1949, 1 cc. 2 per cent novocaine and 1 cc. 55 per cent ethyl alcohol were injected into the muscle cone of the right eye using the previously described technic. A cataract extraction and filtering operation were done on the left eye. The pain in both eyes was relieved. The left eye healed uneventfully and the tension in the left eye remained well controlled. The pain in the right eye recurred and it was enucleated on March 22, 1949, without further use of retrobulbar alcohol injection.

Case 2.—E. L., aged 51 years, was admitted to another hospital October 11, 1949. The right eye had been red and painful for 18 days. The vision in the right eye had been poor for 30 years following an injury. The eye was treated with atropine, compresses and typhoid vaccine intravenously. The tension ranged between 35 and 50 (Schiotz). He was treated with miotics without relief. Paracentesis was done October 19th and repeated October 21st, but the eye remained painful. Retrobulbar alcohol injection was done on the right eye October 24th. There was immediate relief of pain, and the eye improved quickly.

Case 3.—Mrs. A. J., a 45 year old colored female, was seen at the office July 25, 1949, complaining of pain in the right eye for 3 weeks' duration. The eye had been injured 15 years previously and the sight had been weak ever since. Vision was light perception in the right eye and 20/80 corrected to 20/20-2 in the left eye. Examination revealed an inflamed, painful, hard right eye; the lens was dislocated into the vitreous; the left eye was normal. Treatment with miotics did not relieve the pain in the right eye. Enucleation was advised but was refused by the patient. On July 26, 1949, retrobulbar injection of 1 cc. 2 per cent novocaine, followed in a short period of time by 1 cc. 70 per cent ethyl alcohol, was done on the right eye. The pain was relieved immediately, the eye has remained comfortable, and the inflamation has subsided, although the tension remains at a high level. The patient was last seen November 7, 1949, and at that time the tension in the right eye measured 100, but the patient was comfortable.

Case 4.—J. O. Y., a 70 year old while male, was seen September 22, 1949. He complained of loss of vision in the right eye for 1 year and in the left eye for 1 week. He was a diabetic of many years' standing. He was admitted to the Huntington Memorial Hospital for cataract surgery on the right eye October 17, 1949. Vision was light perception in each eye. His diabetes was controlled by diet and small doses of insulin during his stay in the hospital. On October 18, 1949, a combined extracapsular cataract extraction was done on the right eye under local anesthesia. The lens was hypermature. A bead of degenerated vitreous was lost. The postoperative course was stormy. Some lens cortex remained in the anterior chamber and was absorbed slowly. A small hemorrhage appeared in the anterior chamber on the third postoperative day and was absorbed slowly. The eye remained red and painful and there seemed to be considerable danger that the eye would be lost. Examination of the eye was difficult because of the pain and photophobia. On October 27, 1949, the eye was examined, with the patient under general anesthesia. At this time the eye was quite red, but the lens cortex was absorbing and the hyphema was gone. The sutures were removed at that time. The eye remained red and painful, and healing was slow. Finally, on November 11, 1949, under general anesthesia, 1 cc. 70 per cent alcohol was injected into the muscle cone of the right eye. The next day the patient was free of pain and has remained so up to the time last seen. The eye whitened out and vision was corrected to 20/100 on December 10, 1949, and a correcting lens was ordered for him.

Caution.—This procedure should be used only for the relief of pain. The procedure should not be used to relieve pain in eyes in which danger of sympathetic ophthalmia or a tumor exists, and in any such case enucleation should be done.

SUMMARY

A new procedure is described. It has been found to be very valuable in relieving intractable ocular pain. It is relatively safe to use. A series of four cases from my own experience is reported.

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NO MATHEMATICAL FORMULA IN CANCER

How long it will be before we know enough about the biologic processes to be able to interrupt the process at the particular point where normal cell growth transforms into abnormal growth, one cannot say. But it is not going to be a simple process.

We know what it took to develop the atomic bomb, but this was comparatively simple. Although it required a great deal of money, manpower and time, the physicists were able to predict its completion according to mathematical formulas. On the other hand finding the cause and cure of cancer will not be simple because we are dealing with a biologic process which is much more difficult and less predictable since the living cell does not always react according to a mathematical formula. But that does not mean that it cannot be accomplished.

It may require 10 years, 15 years, or even 50 years, but it is a goal worth fighting for, and I hope the time will come when we in the American Cancer Society will collect not the 10½ million that we did last year but many times that figure in order that we will have millions of dollars available for research because it is only through research that we are going to conquer cancer.—Alton Ochsner, M. D., in J. Kansas Med. Soc.

KEEP THE LAMP LIGHTED

There is no profession in which continued alertness to change is more essential than in the practice of medicine. The day is long since gone when the acquisition of a diploma and an occasional "refresher course" kept a physician in touch with advances made in his profession.

It is said that in the past thirty years more medical progress has been made than in the entire previous history of man. There are those who might question such a sweeping statement, but the fact remains that the physician who wishes to serve his patients with the latest findings in the laboratories and hospitals must seize every opportunity to attend postgraduate clinics, participate in programs arranged by medical schools, and keep up as best he can with his reading of specialty journals.—Wisconsin Medical Journal.

A STEP TOWARD DICTATORSHIP*

By A. B. BOWYER, M. D.,
Charleston, W. Va.

However hard he may try, no one can convince me that the American way isn't the best way. Lots of scoffers believe otherwise. They have fallen under the spell of a little word which has been elevated to a Hollywood setting and dressed up with romance. That word is "exotic," which is defined in the dictionary as meaning "introduced from a foreign country; extraneous; foreign."

But many accept it as meaning something entirely different. A smartly dressed woman may feel flattered to be told she looks exotic, or that it's an exotic hat she's wearing.

One of the truly un-American schemes which a good many Americans are embracing in their eagerness to adopt anything "exotic," is socialized medicine — the same kind of unwieldy, cumbersome system of medical procedure that has been tried in Great Britain, and which has proved not only far too costly, but utterly impractical. My organization, the Veterans of Foreign Wars, has taken a definite stand against adoption of socialized medicine in this country. But the proposal has some formidable backing, among its supporters being many university presidents, deans and professors, clergymen, writers, poets, and other intellectuals. They have plumped for it without knowing the facts, or in utter disregard for the unhappy conditions that have resulted in countries where it has been tried.

The Communists also are for socialized medicine, just as they are for anything else that will overcome what they call the "evils of capitalism" and make the people slaves of the state. Nicolai Lenin, one of the gods of the Communists, declared that "socialized medicine is the keystone to the arch of the Socialist State." Bismarck introduced socialized medicine in Germany in 1883. Certainly Bismarck, the so-called Iron Chancellor and a strict adherent to the theory of blood and iron, had no interest in social reform. He was interested in socialized medicine simply because it would strengthen his dictatorial hold upon the people by making them dependent upon the state. And it was Bismarck whose ideas and policies led Germany into two great wars.

Who is advocating socialized medicine in America? Well, there are the "dogooders" who should know better, but permit their names to be used indiscriminately in support of any crackpot

*Script prepared by V. F. W. National Headquarters, Publicity Division, Washington, D. C., and broadcast by Doctor Bowyer, V. F. W. Surgeon General, over Station WKNA Charleston, May 23, 1950.

idea. Then there are the Communists and the other left-wingers, all of whom are ardent champions of the scheme. In the latter case, of course, their aims are those of Bismarck. They want to make the people subservient to the state — against the day when they hope to seize the state and make it their own.

And, to these we must add the many politicians who often don't seem to care what happens to the American people so long as they can be assured of the votes that spell a stranglehold on the offices they occupy.

Just what is socialized medicine? To the "do-gooders," the Communists, the socialists, and the don't-care politicians, it is simply free medical service. No more doctor bills to pay. If you have a headache, a sore toe, or a broken fingernail, just run to the doctor. Everything from fallen arches to a weekend hangover will be taken care of, with no worry over the little first-of-the-month notation, "for professional services." You may have to stand in line with all the hypochondriacs and their imaginary ills, but no matter; it is all free. If your family doctor is too busy with all the additional practice that the government has handed him, your benevolent government will find another for you.

If you are like I am, you are suspicious of anything that is free. I'm always on my guard when I am offered something for nothing.

The Veterans of Foreign Wars organization has made a study of socialized medicine and has found that it will cost a great deal more than our present medical system. And the service you and I would get would not be half as good as that we get now.

Socialized medicine is free only in the sense that you won't pay for it directly, but through taxes. These taxes would be by payroll deduction similar to the social security taxes now paid by employers and employees.

Students of socialized medical systems now in operation estimate that a payroll tax of no less than six per cent would be required just to set up the machinery of national compulsory health insurance. That means that the man earning fifty dollars a week would pay a tax of one hundred and fifty six dollars a year to get the health insurance system going. Of course, this tax would be in addition to the many other burdensome taxes he already is paying.

It is estimated that the medical bill of the average family would be doubled or trebled, and the cost of such a system to the nation has been estimated at from six to eighteen billion dollars a year. Senator Byrd, of Virginia, has predicted that in ten years this figure would reach a total of twenty-three billion dollars a year. This means that eventually you and I would end up paying about ten per cent of our earnings for this so-called free medical service. Think what that would mean. If you earn $300 a month, you would be paying $30 a month, year in and year out, for third-rate medical service. And you would pay, whether you needed the service or not. And what about the veteran? Would he pay? He most certainly would! Under the proposal advanced by the Federal Security Administrator, there is no provision for exempting veterans from payroll tax. That would mean that a veteran eligible for free medical service from the Veterans Administration because of his war service, would be paying just the same to provide production-line pills for the hypochondriacs, and aspirin for the malingerers with weekend hangovers.

I stated that the free medical service we could expect would not be half as good as that we are getting. I venture to say it wouldn't be even that good.

Let's take a look at England, where socialized medicine is a reality. Not long ago, Harold E. Stassen, president of the University of Pennsylvania, went to England and made a study of the system. He made a report of his findings in an article, "Granny is Gone," which appeared in the February, 1950, issue of Reader's Digest.

There was a rush to hospitals," Mr. Stassen wrote. "Swelling the stream were many who were chronically ill and who, previously cared for by relatives, could now be handed over to the government. To make the congestion worse, patients managed to linger in hospital beds. Consequently, in the winter of 1948 and 1949, many patients urgently in need of hospitalization could not get accommodations. In the first year of the program in the London area alone, more than five thousand emergency patients could not find beds. There are no nationwide statistics of such failures but, proportionately, the total would be thirty thousand a year.

"This breakdown of the hospital and medical care for the aged is probably the principal cause for the startling jump in Britain's death rate in the first quarter of 1949 — a rise to one hundred fifty per ten thousand from one hundred twenty-three in the same quarter of 1948.

"If emergency cases cannot get into hospitals, it is hardly surprising that others needing corrective surgery, or attention that is not urgent but is important to long term health, have great difficulty too. At least two hundred thousand Britons are on hospital waiting lists today."

That is what a capable and highly regarded American educator found in his study of socialized medicine in Britain. And that is but part of the story.

The red tape is so cumbersome in England that the average time a doctor can give a patient is only three to four minutes. The doctor, dentist, or nurse must spend considerable time filling out government forms. And, in addition to paying the doctors, dentists, and nurses, your hard-earned tax money would be spent in part to hire thousands of typists, bookkeepers and investigators. In England, according to government figures, it takes four hundred thousand employees to administer the national health service. On a population basis, England having forty-eight million against an estimated one hundred fifty million here, socialized medicine in this country would require the services of at least one million, two hundred thousand additional government employees to administer the health program.

Now what about the personal side of the picture? Under a system of socialized medicine, your health program would be a matter of public record to be scanned and scrutinized by a horde of paid political workers. It might even become a matter of public gossip. Personally, I regard the state of my liver or my stomach to be my own business and that of my family doctor, and not a matter for public discussion.

We don't need government regulation of medicine any more than we need it for the law, or for the other professions. It would prove a very definite step away from free enterprise. It would play into the hands of the Communists and others who are seeking by every possible means to destroy individual initiative and strengthen their objective of governmental control of all the people.

But aside from this great danger, it would place an additional heavy tax burden on the people of the nation. I think all of you will agree that our tax burden is heavy enough as it is. Every wage earner, every person who is self-employed, and every employer eventually would be contributing exorbitant payroll taxes to support the system. Authoritative estimates place this tax at from eight to ten per cent, maybe more. And the huge sums collected from the American taxpayer would not be returned dollar-for-dollar in terms of medical service.

Ask any veteran about sick-call in the service, and ask him if he wishes to return to the long waiting lines, the impersonal "take-this-pill" attitude of the doctors, not to mention the gold-bricks and the hypochondriacs taking up the doctor's valuable time. I think I speak for the veteran when I say the answer is an emphatic "No!"

There are statistics to prove that unprecedented strides have been made in providing medical care for our citizens through voluntary health and hospital programs. These programs represent the American way of doing things.

The members of the Veterans of Foreign Wars have fought to preserve the freedom and the integrity of the individual. They have gone to war against other nations which sought, through force, to regiment and enslave their peoples. Let us continue that fight — and let us heed the message of the British citizen who sent this word to his friends in America: "Never, never, adopt such a program!"

CONQUEST OF WHOOPING COUGH

Last year, for the first time, there were fewer than 1,000 deaths from whooping cough in this country; the final figure, in fact, may be less than 800. This is a landmark in the control of one of the principal communicable diseases of childhood. The increasingly successful efforts against whooping cough take on added significance in the light of the high level of the recent birth rate, which has greatly augmented the number of young children in the population.

The gains against whooping cough have been especially rapid in the last decade. In 1947—a year of relatively high prevalence—the death rate was scarcely one fourth that of only 10 years earlier. The figures for 1948 and 1949 are even more impressive, showing a reduction of nearly 50 per cent from the previous low established in 1946 and a decline of more than 75 per cent as compared with any year prior to 1940.

The per cent decline in the death rate has also been large at the preschool ages, where most of the deaths beyond infancy occur.—Statistical Bulletin, Metropolitan Life Insurance Company.

GOOD CHARACTERISTICS REMAIN

The good characteristics which got us where we are today remain and shall remain the essence of the American physician. Of these, the one most highly prized is that of freedom from control and regimentation.

If our minds should falter within or fail to warn without then it shall be our failure. If, on the other hand, we shall place within our practices the needed spirit and substance to assuage man's soul to better heights, the birthright of good independent practice shall remain ours and the high ideal set out for by the small group of medical scientists when they started in this country at the turn of the century shall not be lost, but rather shall grow into a new renaissance of American medicine.—Anderson Nettleship, M. D., in Mississippi Valley Medical Journal.

Leukemia tops the list as the most common type of fatal cancer in children.—J. Mich. St. Med. Soc.

THE PSYCHIATRIC ASPECTS OF EPILEPSY*†

By JAMES B. FUNKHOUSER, M. D.,
Richmond, Virginia.

It has been estimated that there are 500,000 epileptics in the United States. Therefore, the total problem is as large as that of tuberculosis or diabetes. If the borderline conditions which are now believed to be related to epilepsy were to be counted in, approximately one in 100 persons might be called epileptic. But let us consider only the smaller number, for even at one-half million there are not enough specialists to look after the epileptic population.

If, then, epilepsy is to be properly cared for, the special knowledge that has developed in the past decade must be familiar to all who are practicing medicine. This evening I have nothing original to report. It is my hope, however, that a review of recent progress may contain something new for at least a part of this audience.

Because I am a psychiatrist, my presentation will be slanted to a very small segment of the total epileptic problem, but it is a portion that contains items of interest that possibly have not received the attention they deserve.

A good beginning for any medical review logically starts with the history of the disease which, in the case of epilepsy particularly, extends back to Hippocrates who cynically observed that the goat was just as subject to epilepsy as man and, therefore, the affliction could not possibly be "sacred". At that time the Greeks believed that the seizure was due to divine interference. Later the notion developed that it was due to devils or demons. A passage in the New Testament (St. Mark) is frequently quoted as a classical description of this belief:

> "Master, I have brought unto you my son who has a dumb spirit, and wheresoever he takes him, he tears him, and he foams and gnashes his teeth . . . and often time it has cast him into the fire and into the waters to destroy him."

Much of this ancient superstition of "demon possession" or of divinely afflicted people has persisted down through the centuries. It stimulates the imagination and influences public opinion and attitudes even today.

A recent series of advertisements of a certain drug company depicts "men of genius" who have been afflicted with epilepsy. Of course, this is a revival of Lombroso's idea that epileptics are "superior degenerates" an idea perverted in a good cause, the attempt to destigmatize the name of epilepsy. To name a few who were supposed to have had epilepsy: Mohammed, Napoleon, Caesar, St. Paul, Shubert, Beethoven, Byron, Moliere, Alexander. Religious and military leaders seem particularly susceptible to the suspicion. Van Storch, however, after reviewing the historical evidence was not convinced that all these illustrious men were truly epileptic. I recall that in particularly difficult times Hitler was reported to have fallen to the floor gnashing his teeth and chewing the rug.

Recent technical achievements of electrodiagnosis and pharmacology have resulted in more progress in the past two decades than had been made in the previous two thousand years. It has been pointed out that more than fifty years elapsed between the first use of bromides (1857) and the discovery of phenobarbital (1913), but only twenty-five years elapsed between the discovery of phenobarbital and the invention of dilantin, and then only a few years passed until tridione was found. Now new drugs are being produced rapidly.

An outstanding recent development, the electroencephalograph, has made the clinical study of epilepsy and cerebral function nearly as simple as the study of heart disease by means of the electrocardiograph. The principle of these two machines is essentially the same. Partly through the discoveries made possible by this new machine many of the old conceptions of epilepsy have received scientific validation while others have been forced to undergo critical change.

Among the most important changes to be noted is the fact that we must definitely abandon the traditional separation of the epilepsies into *grand mal* and *petit mal.* The proper understanding and, therefore, the practical treatment of the epileptic is no longer served simply by dividing epilepsy into major and minor seizures.

In an attempt to destigmatize epilepsy (by the familiar device of calling it by another name) the leading epileptologists made it fashionable a few years back to refer to them as the "convulsive disorders." However, it is now apparent that not all epileptic conditions are manifested by convulsions and so this, too, has become an inaccurate and misleading designation. The word, epilepsy, ugly as it may sound, at least has the advantage of being a clinically meaningful term, referring to a group of symptoms with which most everyone in general is familiar.

But now, on the basis of response to the new drugs, on the basis of physiologic investigations,

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†Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are a result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

on the basis of age and, particularly, on the basis of electroencephalographic findings, it is most practical to divide the epilepsies into three groups. Some extra detail will be devoted at this point to the triangular division of clinical epilepsy.

First, of course, there are the familiar convulsive disorders which include classical *grand mal.* This type of epilepsy occurs at any age and is manifested in the brain waves by sharp, sudden, deflections called spikes. This type of epilepsy usually is benefitted by dilantin or phenobarbital, and may be aggravated by tridione.

Secondly, there is the *petit mal* division. This type of epilepsy (which has no clinically remarkable convulsive manifestation) occurs principally in children. It is manifested in nearly every instance by alternating spikes and slow waves in the brain wave tracing. It usually is benefited by tridione and may be aggravated by dilantin. This group includes myoclonic epilepsy and akinetic seizures, and it embraces or is identical with pykno-epliepsy.

And, finally, there is a distinct third type of epilepsy which occurs principally in young adults, seldom in children. It is manifested by focal electroencephalographic abnormality or spikes in one or both temporal lobes and is seldom benefited by medication although it is frequently aggravated by phenobarbital.

The recognition of this third group, psychomotor epilepsy, as a distinct and separate form of epilepsy is of such practical importance that I have chosen to make it the major topic of this discussion.

Psychomotor epilepsy probably embraces and includes the older, loosely organized concepts of "epileptic psychosis", "epileptic fugue", "epileptic furor", "postepileptic confusional state" and "epileptic automatism", but more important it probably includes many cases now diagnosed as hysteria, temper tantrums, somnambulism or psychosis unclassified.

Although he later modified his remarks, Gibbs once stated that psychomotor types of epileptic disturbance in the brain waves are common in problem children, in patients with psychopathic personality, in schizophrenia and in the near relatives of epileptics. But even in a recent report the same author found a large percentage of personality disturbances in the patients with psychomotor epilepsy.

Over half of 300 patients with focal temporal pathology had psychiatric symptomatology. Several had attempted suicide, many had been diagnosed schizophrenic and manic depressive and more than a few had been subjected to electric shock therapy. Gibbs proposed that the epileptic personality, if it really exists, is found almost exclusively in the psychomotor group and noted the report of Belinson who found that 26 per cent of institutionalized epileptics suffered psychomotor seizures, indicating that the behavioral concommitants of temporal lobe disorders are poorly tolerated in the community.

A quite recent report from an army psychiatrist indicates that many of the soldiers who are disciplinary problems or display irrational behavior, or have enuresis, are actually suffering from this form of epilepsy.

Perhaps it would be well to describe a typical psychomotor attack at this point.

The patient behaves as if he were in a "daze". He is confused, disoriented, ataxic and incoordinated. He may spit, or make sucking mouth movements or he may be noisy and aggressive, shuffling the feet and shouting. Like other epileptics, these patients should not be restrained forcibly because they may become more violent.

It is easily understood why this condition is so seldom diagnosed clinically. If it occurs in a patient who is a known epileptic it is easy enough, but if it occurs in a patient who does not have clinical convulsions, it is most likely to be diagnosed erroneously as "hysteria", "psychosis" or "psychopathic behavior".

Incidentally, the differential diagnosis between any type of epilepsy and hysteria has never been as easy as the tabular outlines in the textbooks would have us believe. I shall furnish you with examples which I am sure all of you here can duplicate from personal clinical experience.

A young man was admitted to the hospital complaining of headache, also numbness of his right arm, and that the arm was partly paralyzed. He was seeking a pension. At the time he was hospitalized divorce proceedings had been instituted by his wife who was complaining that he was not supporting her properly. He was a narcissistic, self-centered and very much spoiled young man, dominated by his mother in the marital strife. He had had several "blackout spells" following emotionally stormy scenes. These "blackouts" aggravated the paralysis and numbness of his arms. Under the influence of strong suggestion under sodium amytal he was able to raise his "paralyzed" arm as high as his shoulder, but no farther. His case was diagnosed as hysteria and he was asked to return to the hospital if new symptoms developed, which promptly did: a foot drop, a flaccid arm, a choked disk with blurred vision. Somewhat later this

patient died of glioblastoma. An electroencephalogram taken on his second admission revealed focal brain wave abnormality; had it been taken on initial examination, the diagnosis of hysteria would not have been made.

An adopted child who had recurrent sudden unexplainable attacks of weakness was brought into the clinic. Whenever he was required to do the chores he would fall to the ground without a loss of consciousness. The foster father was an alcoholic and sadistically brutal. The foster mother was oversolicitous and alarmed. She allowed her alarm to be apparent to the child. During the examination she held the child in her lap like an infant, although he was eight years old. He was hyperactive, noisy and undisciplined. This obvious "behavior problem" turned out to have a *petit mal* type of electroencephalogram and his symptoms responded promptly to tridione. As Gibbs has said:

"Epilepsy may appear in many forms and be diagnosed as gastric neurosis, enuresis, schizoid personality, behavior disorders or criminal psychopathy."

I have given these two typical case histories to emphasize how a psychiatric elaboration of history may deceive one into gross error of diagnosis, obscuring the epileptic condition which may be the real basis of the symptoms.

For the past thirty years the Freudians have dominated psychiatric thinking. There has been much serious talk about *petit mal* being a substitution for masturbation and the rhythmical *grand mal* fit as a symbolic representation of regression to intra-uterine behavior levels and of death and rebirth phantasies. The electroencephalogram has effectively dispelled much of this speculation.

But to return to psychomotor epilepsy. Although it is emphasized that it is a separate and distinct type of seizure, it is not implied that it exists only in pure form. Just as a patient may suffer from both *petit mal* seizures and convulsive seizures, so may a patient have both *grand mal* epilepsy and psychomotor seizures. Indeed, this condition is fairly common (although the combination of psychomotor and *petit mal* epilepsy is exceedingly rare). Although the psychomotor epileptic is not a criminal by nature, he frequently is involved with police because of his disease which often makes him appear to be drunk, or which leads to senseless destruction or aggressive behavior. Without an electroencephalogram it is extremely difficult to distinguish such cases from hysteria, psychoses, or malingering.

Before leaving the subject of psychomotor epilepsy it may be well to stress the not infrequent aggravation of psychomotor epilepsy by the barbituate drugs which are so useful in the pure convulsive disorders and very useful adjuncts to dilantin in most cases.

I recall a case of a young man who had recurrent syncopal attacks and anxiety attacks who was considered to be psychoneuotic and was given elixir of phenobarbital for the control of his anxiety. His symptoms were definitely aggravated by this medicine. An electroencephalogram showed psychomotor epilepsy and a closer scrutiny of the history revealed familial epilepsy. Another very similar patient was given intravenous amytal as narcosynthesis for what were thought to be hysterical episodes and this reproduced a condition of typical psychomotor excitement. The electroencephalogram then showed the true nature of his disorder. In one of the cases just cited the symptoms responded to dilantin, which is another point worth noting. Although no drug may yet make fair claim of being specific for psychomotor epilepsy, the anticonvulsants, dilantin, tridione, mesantoin, mebaral, et cetera, occasionally may prove of some benefit in individual cases.

Up to this point I have described matters that generally are accepted by all workers in the field of epilepsy and electroencephalography. There is a wide and very important subject, however, about which matters are far from settled. The question, as yet not satisfactorily answered, can be formulated somewhat as follows: Is there any valid correlation between abnormal brain waves and psychopathic behavior, criminality, hysteria and other miscellaneous neuropsychiatric conditions? A part of this controversy is here quoted for your edification.

Gottlieb, Carlson and Knott found a definite correlation between abnormal brain waves and constitutional psychopaths and behavior problems. About the same time, Simon, O'Leary and Rinne reported 96 army psychopaths with different electroencephalograms no different from those of normal soldiers. Jasper, Solomon and Bradley then reported that 70 per cent of the behavior problems in children (also certain neurotics and psychotics) showed electroencephalographic abnormality. Walker and Kilpatrick on a slightly different tack found that dilantin improved the behavior of problem children without changing the electroencephalogram abnormalities. Gibbs, noting this difference of expert opinion, in his annual review of 1946 warned that the studies on behavior problems and psychopaths were likely to include groups of psychomotor epileptics without seizures. Michaelis and Secunda found no correlation be-

tween behavior disorders and abnormal electroencephalograms when these had been corrected for sex and age (except in enuretics). Simons and Diethelm found the correlation only in certain subgroups of constitutional psychopathic states, i. e., the aggressive psychopaths. Solomon, Droglever and Deutcher found the 12 most abnormal electroencephalograms in the 20 best behaved problem children. Silverman and Rosanoff found a slight correlation with homosexuality. Gottlieb, Carlson and Knott then repeated their work, correcting for the age factor, and found no correlation of constitutional psychopathic states, but still insisted that it correlated with primary behavior disorders in children. Hill and Watterson, in England, reported that 65 per cent of aggressive psychopaths showed abnormal electroencephalograms. Bradley and Jenkins reported 65 per cent of behavior problems had abnormal electroencephalograms, 41 per cent of schizophrenics and 16 per cent of controls. Hill and Watterson, however, in their report of aggressive psychopaths, state that the records of young psychopaths would pass for normal children. Hill also reported that the record of aggressive psychopths with amnesia were indistinguishable from epileptic records and showed a right temporal slowing. (Gibbs, I think, would call these cases psychomotor epilepsy.) Nagler, Politan and Pacella found no correlation with obsessive compulsive neurosis. Gibbs, Bagshi and Bloomberg found no correlation between abnormal electroencephalograms in behavior disorders in children. Rockwell and Simons correlated their abnormal electroencephalograms with obessive compulsive behavior disorders, but seemed to be talking about constitutional psychopathic states, because they included "the superior degenerates of Charcot" amongst their obsessive compulsives.

The crux of the matter may be the inexactitude of neuropsychiatric nomenclatures. Thus a "Tower of Babel" has risen among the electroencephalographers who are chiefly neurophysiologists. Psychiatric nomenclature is notoriously inexact. What one might call an obsessive compulsive state, another might call a constitutional psychopath, and yet another would consider a case schizophrenia.

But through all this muddled haze one thing seems to be growing more clear. Though it cannot yet be stated with absolute finality, it seems that certain behavior problems, certain psychopaths and hysterics, and a great many miscellaneous personality deviations that are not now classified as epilepsy do manifest abnormal brain waves which are similar and, in some cases, indistinguishable from the brain waves of epileptics.

In conclusion, I will briefly touch upon an unpopular subject, the "epileptic personality." Not because of any personal belief or disbelief but because my assigned subject is "The Psychiatric Aspects of Epilepsy", I will briefly review this old and possibly outmoded conception for the sake of completeness. In the last edition of "Diseases of the Nervous System" (Jelliffe and White), the epileptic personality was described as it was generally held to exist by the last generation of medical men. It was finally stated that the clinical picture was so definite that a good neuropsychiatrist should be able to make a diagnosis of epilepsy on the basis of the patient's personality makeup "without a knowledge of convulsions". A peevish, sensitive, egocentric, impulsive, sadistic, antisocial patient, with "plateau speech" and often physical stigmata, was described. It is the argument of the leading epileptologists today that what they were describing was the result of institutionalization and chronic drug intoxication, particularly as a result of bromides. However, even in the latest edition of Henderson and Gillespie, more than passing mention is made of the epileptic's personality. It is stated that even before seizures develop in an epileptic such a personality is present, and that the end product appears to be an aggravation and accentuation of the preconvulsive personality characteristics seen in childhood. These seem to tie up with some of the controversial literature just quoted. May not these behavior problems in children reported to have epileptic type of disturbances in the electroencephalograms be the same as those in children described by Clark as pre-epileptic?

The notions of "epileptic personality" have been subjected to criticism by leading epileptologists, although men who are taking care of large numbers of epileptics in institutions and state hospitals have, perhaps significantly, very little to say.

The Rorschach, Wechsler-Bellevue, and other psychologic technics now tend to show that the epileptic is no different from any one else in so far as personality configuration is concerned. Some, indeed, have proven that the epileptic is of superior intelligence, but this, I think, tends to remind the skeptic of Hamlet's remark "Methinks the lady doth protest too much".

I do not see why we must abandon belief in the epileptic personality — at least not until the controversy about behavior problems and psychopaths resolves itself and it is definitely shown that these conditions are not some sort of "epileptic equivalent". It does not seem too big a step from the aggressive psychopath which some re-

port as having an abnormal electroencephalogram to the irritable, impulsive, self-centered person Clark and McCurdy described as the epileptic personality.

The enthusiasm of the leaders in the fight against epilepsy is that of men who are winning a battle. More than this, they are either reverent or gleeful each time their discoveries tend to confirm the brilliant surmises and deductions of Hughlings Jackson or of Gowers and other pioneers in the field of epilepsy. The principal scientific instrument at their command is the electroencephalogram (paradoxically enough, an invention of a psychiatrist, initially ignored by physiologists). The "psychologic warfare" against the stigma of epilepsy quite naturally has been directed against the concept of the "epileptic personality", but the electroencephalogram is not a propaganda machine. Just as the ideas of Hughlings Jackson and Gowers are being proved by the electroencephalograph, so too may be the observations of White, Clark and McCurdy. Bergers' hope that his machine might be useful to psychiatry may someday be realized.

It would be better for humanity if it is eventually found that constitutional psychopaths and behavior problems are closely related to epilepsy. Certainly psychotherapy has failed to make any impressively successful attack on functional disorders of this kind in the same period that the pharmacologists have reduced by one-third the symptoms of epilepsy. If psychopaths and behavior problem persons can be definitely shown, even in a few instances, to be suffering from epileptic equivalents, there may be more hope for them than exists otherwise.

An operation on the anterior temporal lobe in certain selected cases of psychomotor epilepsy has succeeded in producing at least a tempory remission of symptoms. The pendulum of history swings slowly backwards and we find ourselves at the beginning of the history's cycle. The trephined skulls remaining from the neolithic age suggest that we have returned to prehistoric devices to release the devil from the brain. The psychoanalyst has taken a back seat at least temporarily while the pharmacologist has come again into his own in the treatment of the falling disease.

It is encouraging that although the pendulum swings to and fro, the hands of the clock make progress. The general outlook for epileptics is better and better, and this improvement is gaining momentum. There is reason to believe that since we can now control most of the epileptic's seizures, we will soon be able to control the remainder.

Perhaps many patients now diagnosed as psychopaths, behavior problems, hysterics, or as insane some day may be referred to the surgeon or better still may take our prescriptions to be filled at the corner drugstore.

KHELLIN IN ANGINA PECTORIS

A centuries-old Egyptian drug, effective in controlling muscular spasm, is now regarded as a powerful aid in combatting angina pectoris, accounted the most painful of all heart diseases. This subject was discussed at length at an American Chemical Society symposium at the University of Notre Dame.

The drug, called khellin, was said by Dr. Rene Wegria, Assistant Professor of Medicine at Columbia University College of Physicians and Surgeons, to have a far more lasting effect than other comparable compounds in treating angina pectoris. Thus it was stated that khellin retains its effect up to six hours after administration, as compared with only a few minutes for nitroglycerine, that other effective sedative.

Angina, described as a pain caused by a lack of oxygen in the heart muscle, was said to be relieved by khellin because by increasing the flow of blood to the heart muscle it also increases the supply of oxygen.

A few years ago Dr. George von Anrep, Professor of Cardiac Physiology at the University of Cairo, showed that khellin had marked activity on coronary vessels, and this was confirmed by experiments in this country.

The view was expressed by Dr. Arthur Stoll, world authority on heart drugs, that ultimately the physician will have an arsenal of such drugs, each for a particular form of heart disease.—Think.

THIS BUSINESS OF GROWING OLD

Aging is growth. It is an achievement—not a penalty. We should not be old except as we grow old.

Our 1950 census shows that over 11 million people, or 7.7 per cent of our population, are over 65 years of age, and 15 million are over 60 years of age. Indications are that the proportion of elderly in the country will increase sharply in the next generation.

Aging is not synonymous with chronic disease. One can be old and be in good health. The prevalence of chronic diseases, however, increases with age. Almost all the chronic diseases are intimately associated with advancing years. The problems incident to the care of chronic illness on a community basis are manifold. These not only involve clinical medicine but also facilities for care, rehabilitation and employment opportunities for the handicapped. Many agencies, organizations and physicians have contributed in various ways over the years to provide care for these aging people. Every effort is being made to stimulate the attack upon the problem of coordinating efforts on the part of city, county, social and private agencies, and the medical profession.—New York Medicine.

Through efforts of UNRRA, WHO and the U. S. mission to Greece which have employed DDT to combat malaria, cases of this disease in Greece have dropped from 2 million to 50 thousand.—R. N.

TUBERCULOSIS ABSTRACTS*

NUTRITION AND INFECTION

Every mother of a family, and every doctor in practice, firmly believes that the best bulwark against infection is good wholesome food. The association of tuberculosis with poverty and malnutrition is particularly noteworthy. In the late war the countries with the highest incidence of tuberculosis were those that suffered the greatest privations and food shortages. But, other factors besides nutrition may well have been involved.

The poorly fed community often suffers from fatigue, low morale, anxiety, overcrowding, and poor hygiene, and its hospital and public health organizations are likely to be defective. Moreover, in spite of the appallingly low nutritional standards in Germany at the end of the war, there were no major epidemics. Then again, children brought up in apparently admirable living and dietary conditions still contact measles, chickenpox, mumps, and poliomyelitis, and well-fed adults catch colds and influenza.

Poliomyelitis, indeed, seems to have a predilection for young adults in excellent physical condition; and the incidence appears to be much higher in well-fed countries like the United States than in, for example, the ill-nourished African. Most bacteriologists, therefore, hesitate to accept the view that malnutrition increases susceptibility to infection.

The influence of heredity, both in the host and the infecting organism, cannot be overlooked. Webster, by inbreeding and selecting from a common stock of mice, bred two strains, one of which was almost completely immune to a given infective dose of *Salmonella enteritidis*, the other suffered almost a 100% mortality. Such inbreeding and selection, however, did not produce resistance to other organisms.

If nutrition plays a part in the resistance to infection, one would expect antibody production to be affected, particularly as antibodies are derived from the serum proteins, which are lowered in frank malnutrition.

At the end of the war Gell had an exceptional opportunity for studying the relation between protein deficiency and antibody response in patients and prisoners from the Ruhr suffering from malnutrition—they were on a diet of only 1000 calories daily. Their antibody response, as measured by agglutination tests, was determined before and after infection with a rather bizarre mixture of tobacco mosaic virus and avian red cells, chosen because there could not be preformed latent immunity to them. British troops served as controls. The results showed that the well-nourished British soldier had a better antibody response than the half-starved German, but the differences, though statistically significant, were not as great as might be anticipated. Gell concluded that "under-nutrition does not play as large a part in widespread epidemics as is generally supposed."

Vitamin C was once thought to be associated with immunity mechanisms in the body, but evidence is not very convincing. Early work indicating a direct correlation between blood vitamin-C levels and complement formation has not been confirmed. On the other hand, a controlled experiment of Glazerbrook and Scott Thomson in 1938 seemed to show a definite increase in the resistance of schoolboys against tonsilitis, pneumonia, and acute rheumatism—but not colds—when they were given full doses of vitamin C.

There is evidence that vitamin C is bacteriostatic, but only in concentrations that could never be reached in the body. Large quantities of vitamin-C are often given to patients with infections because their excretion of the vitamin is diminished, but whether the vitamin-C level in the tissues and blood of the normal person affects his susceptibility to infection or the virulence of the attack is improven. Vitamin-A has been named the "anti-infective vitamin" without very firm evidence.

Much work has been done in the last decade on the effect of nutrition in experimental infections in animals but most of it presents such confusing and, at times, conflicting results that it is difficult to draw any general conclusions. Experimental work on viruses, however, has established that the virus and the cells of its host compete for nutrients that are essential for vital enzyme mechanisms in both.

If the virus prevents the host cells from utilizing these essential nutrients, and appropriates them for its own purposes, then the host cells will suffer and may eventually die. Conversely, if the virus is starved of some of its essential nutrients, it cannot live. Viruses thrive best in tissues whose metabolism is active—as in the developing hen's egg—and the typical picture of several virus diseases in animals can be markedly altered by a variety of dietary deficiencies. Animals on diets deficient in members of the vitamin-B complex often show a heightened resistance to some viruses, such as that of poliomyelitis, so that if they do become infected the disease runs a mild course. This and the low incidence of poliomyelitis among poorly nourished people may be examples of "starving out the virus."

With bacterial and protozoal infections a deficiency in vitamin-B complex generally increases susceptibility to infection. Lack of some members of the B complex produces leucopenia, which interferes with phagocytosis. Interesting as these experimental observations are, we must not assume that they have an immediate application to human problems. Nevertheless, Howie suggests that experiments on mice "offer the best hope of giving shape to the present vague mass of information."

Ed—The Lancet—London: Saturday, December 24, 1949.

A clinic for diabetes is justified by exactly the same reason that justifies the existence of clinics for crippled children, well babies, prenatal patients, and cancer detection. Although it is not communicable like tuberculosis and venereal diseases, diabetes offers an open field to the practice of preventive medicine.—W. B. Hunter, M. D., in N. C. Med. J.

*Issued monthly by the National Tuberculosis Association and furnished through the courtesy of The West Virginia Tuberculosis and Health Association.

COLLEGE OF PHYSICIANS
OF PHILADELPHIA

The President's Page

In setting up a procurement, allocation and deferment committee for physicians eligible to call for active service with our Armed Forces, the Council has acted both wisely and well.

Now that the Doctor-Draft bill has been signed by the President, it is a matter of but days until all of the doctors in this state under fifty-one years of age must register. Almost immediately thereafter, we are told, calls will be issued by Selective Service for doctors for active duty, and then Selective Service will call upon organized medicine the country over for advice and help in the selection of doctors whose names will appear on the various registers.

The committee or board, presently named the "Armed Services Advisory Committee," is composed of doctors who enjoy the respect and confidence of their confreres, doctors who will no doubt weigh every case carefully before a decision is reached. This work cannot be done by seven men alone. They will need the aid and counsel of members of similar committees set up by component societies.

The task ahead will not be easy, but it is something that has to be done and I have full confidence that those who have been and will be selected for this particular service will accept appointment without hesitation. Likewise, I believe that the doctors selected under the doctor-draft law will respond willingly to their country's call to active duty.

We are proud of the record of West Virginia doctors in World War II, and we shall be equally proud of our doctors who serve during the present emergency.

C. E. Watkins

President.

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THE DOCTOR DRAFT

The records in the headquarters offices of the West Virginia State Medical Association show that, on September 23, 1942, 340 West Virginia doctors had accepted commissions in the Medical Corps of the Army and Navy. This list had grown to 416 by the end of World War II. West Virginia supplied more than a hundred doctors in excess of the quota fixed for this state.

The matter of service by our doctors in the armed forces during World War II is something of which we have always been proud. Little did we think at war's end that it would be necessary within another five years for our doctors to leave their homes and practice again in order to provide medical service for our armed forces in various parts of the world.

The emergency is here, and the verdict of Congress in favor of a doctor draft must be accepted. We believe that there is general agreement among our doctors with the method that has been provided for the issuance of calls to active duty.

What our quota will be under the first call is not now known, but we do know that under the provisions of the new bill signed by the President early in September, every doctor who has not reached his 51st birthday will be required to register.

Full cooperation has been pledged by the Council, and the selection, allocation and deferment board named by that body will serve exclusively in an advisory capacity to Selective Service and the Armed Forces.

The draft of doctors at a time when the doctor shortage is most critical in this state puts an added burden upon the profession to provide medical care in areas where the shortage of medical personnel will be felt most severely. We have every confidence that the doctors who remain at home will assume these added responsibilities and leave no stone unturned to provide adequate medical care for all of our people.

INCREASE THE APPROPRIATION

Dr. N. H. Dyer, in the annual report of the state department of health for the fiscal year 1949-50, states that during that period about 1,000 citizens requested assistance from the cancer control program. This was an increase of about 160 applicants over the previous year and resulted in the complete exhaustion of funds for the purpose of aiding the needy secure diagnosis and treatment of cancer. These persons were referred to this service by practicing physicians in the state and local health and welfare agencies.

The need for additional funds for the treatment and control of cancer is more and more apparent, and Doctor Dyer's report substantiates the need for an appropriation of at least one hundred thousand dollars a year, asked for in a resolution unanimously adopted by the House of Delegates of the West Virginia State Medical Association at the annual meeting at White Sulphur Springs.

The present appropriation of seventy-five thousand dollars per annum is not sufficient, and it is to be hoped that the legislature will increase this amount to at least one hundred thousand dollars.

Doctor Dyer states in his report that during the past year provision was made for diagnostic services in general hospitals, with patients needing treatment being assigned to a nearby treatment center for surgery, x-ray, and radium therapy. "Follow-up work," he says, "indicates the value of this life-saving program. For instance, at least 126 persons are known to be living today as the result of treatment provided during 1944-45."

Copies of the resolution recommending an increase in funds for cancer control were mailed to all of the candidates for the Senate and House of Delegates, and the response has been most favorable. Members of the State Medical Association should talk personally with all of the can-

didates for the legislature and insist upon an appropriation sufficient to expand the services of the division of cancer control of the state health department to meet present needs.

ALFRED W. STACK

The many members of the West Virginia State Medical Association who were personally acquainted with Mr. Alfred W. Stack, for many years director of the AMA Membership and Fellowship Department, will regret to hear of his death, which occurred August 4, 1950, following an appendectomy.

Mr. Stack was an efficient and faithful executive of the parent organization, and had charge of the tremendous task of keeping current a roster of all the members of the American Medical Association. His loss will be felt severely by the AMA. On behalf of the members of the State Medical Association, we extend sympathy to his family.

LOOK AT THE FIGURES

Those who beat the drums for compulsory government medical care — which is a polite way of saying political domination of our medical system — seem to work on the theory that American people have almost no way of dealing with the financial exigencies connected with illness.

The truth is, however, that in the last 20 years this country has made remarkable progress in the field of medical economics. And it has made it through voluntary health insurance plans, of which hundreds are in existence. Some are sponsored by doctors and hospitals. Others are offered by insurance companies. Still others have been established by industry, labor unions and fraternal groups. In each case, the cost is low — and in each case they do much to take the economic shock out of illness.

In 1946, only four years ago, 40,000,000 people were enrolled in these plans. By 1949 the number had advanced to 61,000,000. At present the figure is approximately 70,000,000. And within the next three years, authorities on the subject forecast, 90,000,000 people will have this form of financial protection. This certainly proves that we, as a nation, can take care of the sickness problem without following the ruinous "let the government do everything" line.

There is, of course, a comparatively small number of people who are unable to buy any protection for themselves. In those cases, there is a legitimate field for governmental aid. But that certainly shouldn't mean compulsory state medicine for all of us — at an unknown cost to the taxpayers.— *Wheeling News Register.*

GENERAL NEWS

GROUP NAMED TO SERVE AS SELECTION, ALLOCATION, DEFERMENT COMMITTEE

A special meeting of the Council of the West Virginia State Medical Association was held at Charleston, August 27, to consider the request of Second Army Area officials for advisory aid in the matter of procurement of doctors for service in our Armed Forces. Several methods for procurement and allocation were considered, including the suggestion that area officials use such methods as they deem advisable in the activation of reserve officers, but that ASTP doctors be drawn by means of a lottery.

The further suggestion was made that ASTP doctors be drawn by lottery by categories, so that doctors in a particular specialty would be called only when the need arises.

The following resolution, submitted by Dr. James S. Klumpp, of Huntington, was unanimously adopted:

"BE IT RESOLVED, That the Council of the West Virginia State Medical Association will cooperate in every way possible with the medical departments of the Armed Services, through action of the Council or designated committees thereof, in the procurement and allocation of physicians to serve as medical officers in accordance with the regulations and policies of the three services; and,

"BE IT FURTHER RESOLVED, That, when and if a physician's draft law is enacted, the Council, acting as a body or through properly designated committees, will activate and administer the procurement, allocation, and deferment of medical personnel affected by such law in accordance with the provisions thereof.

"The President of the State Medical Association is hereby empowered to name, with the advice of the Council, a committee of seven members of the State Association, selected on a geographical basis in order that each councillor district of the state will have representation thereon, with the seventh appointee serving as chairman, to serve as a selection, allocation, and deferment board for physicians eligible for call to duty with the Armed Services, in accordance with the regulations and policies of the Army, Navy, and Air Force, or any national legislation affecting or pertaining to military service of any physician practicing in the State of West Virginia.

"The decisions of this committee shall be final in every case, by vote of a majority of said committee at any meeting thereof, or by a poll of the entire committee conducted in writing."

Armed Services Advisory Committee

Following the adoption of the resolution, the President, Dr. Charles E. Watkins, of Oak Hill, with the full approval of the Council, named the following doctors as members of the Armed Services Advisory Committee for the procurement, allocation, and deferment of doctors:

Russel Kessel, Charleston, Chairman; First district, L. Rush Lambert, Fairmont; second, Justus C. Pickett, Morgantown; third, Sobisca S. Hall, Clarksburg; fourth, James S. Klumpp, Huntington; fifth, H. C. Hays, Williamson; and sixth, C. A. Smith, Beckley.

Statement of Principles Indorsed

The following statement of principles adopted by the American Medical Association with reference to the matter of calling up doctors for service was unanimously indorsed:

(1) Former students in ASTP or V-12 programs and persons deferred during World War II in order to continue their medical education and who have had no active duty.

(2) Those deferred previously for other than physical disability and those previously rejected for physical disability who may be found fit on the basis of present physical requirements.

(3) Former students in ASTP or V-12 programs who served on active duty as commissioned officers for less than 21 months (exclusive of time in postgraduate training).

(4) Those who served less than 90 days on active honorable military or naval duty.

(5) Those whose total active honorable military or naval duty is less than 21 months.

Reserve Officers Called

Doctor Watkins reported in detail the matter of the request of Second Army officials for a recommendation by the State Medical Association concerning five reserve officers who were to be selected for service not later than September 10, 1950, and who would be called for active duty October 1. (Ed: Subsequently, one West Virginia doctor volunteered for service, reducing to four the number of reservists to be called).

The Council went on record unanimously in favor of Army officials selecting the reserve officers to be called for September 10, it being the feeling of the members that, due to the time element involved, Army officials themselves are more capable of making the selection than the members of the Council.

Doctor Watkins was authorized to report the action of the Council to Second Army officials without delay, and the Executive Secretary was directed to notify members of the West Virginia delegation in Congress of the action taken with reference to calling up doctors for service in the Armed Forces, and it was understood that similar notices were to be sent to the Surgeon General of the Army and the Surgeon General of the Navy.

Doctor-Press-Radio Code of Ethics

The chairman was authorized to appoint a Coordinating Committee to prepare a doctor-press-radio Code of Ethics in consultation and cooperation with representatives of the other two groups.

"Committee of 55"

The chairman and the president were authorized to appoint a committee to be known as the "Committee of 55," to be composed of one member from each of the fifty-five counties in West Virginia, to cooperate with the Fact Finding and Legislative Committee in seeking passage at the 1951 session of the legislature of legislation creating a four-year school of medicine and dentistry.

The president and chairman were also authorized to name from the committee to be set up, a special steering committee to work actively with the Fact Finding and Legislative Committee before and during the next session of the legislature in all matters pertaining to the proposed four-year school.

Hospital Relations Committee Reports

Dr. Upshur Higginbotham, chairman of the Special Committee on Hospital Service Plans, reported that he and the other two members of the committee, Dr. Cecil O. Post, of Clarksburg, and Dr. Ross P. Daniel, of Beckley, had a conference with Mr. Robert A. Crichton, Insurance Commissioner, with reference to the recommended elimination from all hospital service plans of provisions for furnishing radiology, pathology and anesthesiology. He reported that the Insurance Commissioner stated that he does not believe that the matter of the practice of medicine by hospitals can be settled by his department, but that, on the other hand, the department is concerned in making sure that holders of hospital service plan contracts receive the benefits provided for in such contracts, whether by the hospital, or by doctors.

Doctor Higginbotham stated further that the Insurance Commissioner made it plain to the members of his committee that he does not believe that it is incumbent upon his department to enforce the ruling of the Attorney General or to require changes in hospital service plan contracts that might reduce the benefits of present contract holders or make it necessary for such contract holders to pay more for such benefits which might be provided through a separate contract for medical service.

The report of the committee was accepted, and it was ordered that the duties of this separate committee be taken over by the regularly appointed Hospital Relations Committee now composed of Dr. Cecil O. Post, of Clarksburg, and Dr. Robert J. Reed, Jr., of Wheeling, the name of Dr. R. J. Wilkinson, of Huntington, having been deleted as a member at his own request.

Dr. Upshur Higginbotham, of Bluefield, and Dr. Ross P. Daniel, of Beckley, were named as members of the committee and Doctor Higginbotham was designated as chairman.

The suggestion was made by Doctor Higginbotham that a special Committee on Hospital Relations be set up in each component society.

NEW UMW AREA MEDICAL ADMINISTRATOR

Dr. John T. Morrison, of Charleston, who has served as UMW Area Medical Administrator for the past two years, has accepted appointment as assistant to Dr. Warren F. Draper, Executive Medical Officer for the UMW Welfare and Retirement Fund. He assumed his new duties in Washington on September 1, and has offices at 907 15th Street, N. W., in that city.

Before coming to Charleston, Doctor Morrison was associated with the Commonwealth Foundation, with offices in New York City.

Dr. Edwin G. Riley, who was formerly engaged in public health work in Florida, succeeds Doctor Morrison as UMW Area Medical Administrator in the Charleston area. He has just received his master's degree in public health from Johns Hopkins University, Baltimore.

PG COURSE IN USE OF CORTISONE AND ACTH AT CHARLESTON, OCTOBER 4

Representatives of the medical profession from practically every section of West Virginia will attend the one-day postgraduate course in the use of ACTH and cortisone, which is being sponsored by Kanawha Medical Society and which will be held October 4, 1950, at the Daniel Boone Hotel, in Charleston.

The following program will be presented by members of the faculty of Northwestern Medical School, Chicago:

"The Metabolic Physiologic Effects of ACTH"—Smith Freeman, M. D., Professor of Research in Medicine.

"The Use of ACTH in the Treatment of Arthritis and Other Collagen Diseases"—David E. Markson, M. D., Assistant Professor of Medicine.

"The Use of ACTH in the Management of Allergic Diseases"—Theron G. Randolph, M. D., Chief of the Department of Allergy.

"The Effects of ACTH on Bone Marrow Function: Its Usefulness in Several Disease States"—Henry Wilson, Jr., M. D., Associate Professor of Medicine.

The speaking program will begin at 9:00 A. M., and the meeting will be recessed for luncheon at noon. The afternoon program will start at two o'clock. There will be a panel discussion from four to five o'clock, in which the four speakers will participate and answer and discuss questions submitted in writing by members of the audience.

Motion pictures and slides will be used by the speakers and there will be practical demonstrations of the use of ACTH at both morning and afternoon sessions.

The whole program has been arranged with the idea of providing up-to-the-minute information concerning ACTH and cortisone. An invitation has been extended to all members of the West Virginia State Medical Association to attend the meeting.

The registration fee of $3.00 includes the luncheon, and reservations are being received by Dr. V. L. Peterson, chairman of the education committee of Kanawha Medical Society. His address is Medical Arts Building, Charleston 1, West Virginia.

DOCTOR ESCUE HEADS NEW BOARD

Dr. Henry M. Escue, of Charleston, has been named chairman of the new Workmen's Compensation Medical Advisory Board. The other members are Drs. Howard A. Swart and Russel Kessel, both of Charleston. The appointments were made by Curtis B. Trent, Jr., Compensation Commissioner.

The Board will pass upon complicated questions and interpret reports filed by medical examiners from over the state. The appointments are for the year ending July 31, 1951.

AMA NAMES NEW OFFICIAL

Mr. Charles T. Baker, who was recently appointed assistant to the late A. W. Stack, director of the AMA Department of Membership and Fellowship, has been named acting director of the department. Mr. Stack died suddenly August 4, 1950, following an operation for appendicitis.

LONGER CAMPING PERIOD ARRANGED FOR DIABETIC CHILDREN IN 1951

West Virginia's first camp for diabetic children, sponsored by the Committee on Diabetes of the West Virginia State Medical Association and held August 27-September 3, 1950, proved to be such a success from every standpoint that already plans are being made for expanded facilities and a longer camping period in 1951. West Virginia is one of thirteen states in which camps for diabetic children have been conducted during the present year.

Camp Kno-Koma was donated by Carbide and Carbon Chemical Corporation. It is located at Cliffside, on Coal River, one mile below Alum Creek. A total of thirty-four children from six to fourteen years of age were enrolled at the camp. There were fifteen boys and nineteen girls.

Activities consisted of woodwork, swimming, riflery, basketball, and other sports, square dancing, movies, and a camp fire. At the end of the week, eleven of the fifteen boys qualified as promarksmen and were awarded certificates.

Notwithstanding the fact that there was rain each day during the camping period, the children were swimming twice a day. They were checked before each swimming period. While several were homesick the first day, they soon became accustomed to the camp and seemed to enjoy every minute of their stay there.

Insulin shots were given every morning and there were four urinal and two blood sugar tests each day.

Each child was given a group picture of the camp, together with two "dog tags." One tag had imprinted on it the name of the child, address, and telephone number. The other tag was inscribed, "I am a diabetic. Give me sugar. Call a doctor." The tags were furnished by Carbide and Carbon Chemical Corporation, and the children were encouraged to wear them at all times.

Dr. George P. Heffner, of Charleston, Chairman of the Diabetes Committee, has reported that more than one thousand dollars was donated for the expenses of the camp.

Dr. Pidd Miller, of Charleston General Hospital, was the camp physician and was on duty twenty-four hours a day. Roland Hamilton was the camp director, and Kathryn Lynch was in charge of the crafts. Anna Belle Dorsey, of Camden-Clark Hospital, Parkersburg, served as dietician, and Ann Linn, of the same hospital, was technician. Three nurses, Misses Mary Flynn, of Morgantown, and Jean Cobb and Marilyn Ferguson, of Charleston, were on duty during the camping period.

POLIO PLANNING COMMITTEE NAMED

A state Polio Planning Committee has been organized with T. Sterling Evans, of Charleston, state representative of the National Foundation for Infantile Paralysis, as chairman. Dr. N. H. Dyer, state director of health, is vice chairman. Miss Lillian Serey, executive secretary of the Society for Crippled Children and Adults, was named secretary.

The committee pledged full cooperation with the recently appointed State Health Planning Committee.

AMA CLINICAL SESSION AT CLEVELAND, DEC. 5-8

The first release of the American Medical Association with reference to the Fourth Clinical Session, which will be held in Cleveland, December 5-8, 1950, describes in detail the program and special features that will be presented.

Outstanding clinical teachers with recognized ability as speakers will headline the scientific demonstrations, and actual cases will be presented and discussed. Diagnoses, treatment and preventive measures as they fit into daily practice will receive the greatest attention.

Each clinical session will be limited to an attendance of 100 physicians. These small groups will make it possible for the general practitioner to enter actively into the discussion and to inquire about his own cases. Leading men in each of the fields under discussion will be available to help with the problems presented.

In obstetrics, difficult cases of interest will be featured. Especially stressed will be the general subjects of breech deliveries, induction of labor, indications for cesarean section, obstetric analgesia and anesthesia, and hemorrhages.

Clinical discussions featuring actual pediatrics patients have been programmed. The care of premature infants, acute diarrhea in children, rheumatic fever, preventive medical measures and psychiatric care for small children are among the interesting topics scheduled.

Because of the unusual interest displayed last year in the section devoted to management of heart cases, there will be a similar session this year. It will include discussions on hypertension, recent advances in drug therapy, including ACTH as it applies to heart disease, acute arterial occlusion and cardiac arrhythmias.

An excellent program has been arranged covering diabetes. This will include diagnosis, vascular complications, special consideration in pregnancy and surgery, and dietary problems.

New developments and refinements of old techniques will feature the discussions on anesthesiology. Spinal anesthesia, management of the surgical case, intravenous administration and other practical problems will be reviewed.

Newest advances in medicine and the use of many newer drugs and their application to the general practice of medicine will be presented in another section. Of special interest will be the discussions on the use of antibiotics, hormones and antispasmodics.

Once again color television will take its place on the program. A schedule of surgery, clinical treatment and examination will be telecast from the Western Reserve School of Medicine to the auditorium. It will be sponsored by Smith, Kline & French Laboratories.

The meeting will be held in the Cleveland Municipal Auditorium, and all meetings of the House of Delegates are scheduled for the Statler Hotel.

Dr. Walter E. Vest, of Huntington, and Dr. George F. Evans, of Clarksburg, will attend the meeting as delegates from West Virginia.

Anxiety is best managed through sharing and communication of the problem with other persons.—W. S. R. in Detroit Medical News.

HEALTH PLANNING COMMITTEE LAUDS WORK OF CIVIL DEFENSE COMMITTEES

The initial meeting of the West Virginia Citizen's Health Planning Committee, an independent health organization recently created by Gov. Okey L. Patteson, was held in Charleston, September 8, with sixteen members of the 22-member committee present.

While the meeting was devoted principally to routine organizational matters, the chairman Dr. W. J. Scarborough, of Buckhannon, presented the matter of the civilian defense program in West Virginia. Dr. N. H. Dyer, state director of health, and chief of the medical division of civilian defense, and Major E. M. Sites, deputy director of civilian defense, outlined the program that has been adopted for use in this state.

The following resolution on civilian defense was unanimously adopted:

> "Be it resolved that the West Virginia Citizen's Health Planning Committee go on record as commending the state and local Civil Defense Committees, the state and local Medical Associations, and the state and local Health Departments for their efforts in cooperating and coordinating their work in Civil Defense, and that we recommend these efforts be continued and extended in all activities relating to the health of our people in time of disaster."

Mr. E. J. Hall, of Charleston, health education consultant of the state department of health, was named temporary executive secretary. The following is a list of standing committees named:

Survey: Dr. John M. Slack, Morgantown, Chairman; H. A. Stroud, Fairmont; and Miss Martha Woodell, Clarksburg.

Coordination of State Agencies: Dr. Deane F. Brooke, Beckley, Chairman; Dr. John W. Davis, Institute; and W. Ross Batson, D. D. S., Pine Grove.

Legislation: George Bryson, Welch, Chairman; C. A. Duffeld, Jr., Sutton; and Mrs. Dale Thomas, Charleston.

Finance: Essie E. Bailey, Princeton, Chairman; Dr. Paul McCuskey, Parkersburg; and Sattis Simmons, Ripley.

Publicity: Dr. W. J. Scarborough, Buckhannon, Chairman, and E. J. Hall, Charleston.

The next meeting of the committee will be held October 14, in Charleston.

RADIOLOGICAL SOCIETY SCHEDULES MEETING

The 36th annual meeting of the Radiological Society of North America will be held in Chicago, December 10-15, 1950. All scientific and technical sessions will be held in the Palmer House and scientific exhibits will be displayed there.

Dr. Warren W. Furey, of Chicago, is president of the Society, and he has announced that more than sixty papers will be presented on the program, and that certain refresher courses will be provided. Dr. Wendel G. Scott, of St. Louis, will present the annual Carmen Lecture.

A general invitation has been extended to members of the medical profession to attend the meeting.

GROUP RECOMMENDS APPOINTMENT OF HEALTH COUNCILS IN SCHOOLS

The Second Annual Working Conference on School Health, sponsored by the state department of health, the state department of education, and West Virginia University, was held August 21-25, at Jackson's Mill. The conference was attended by 125 persons from various parts of the state.

The West Virginia State Medical Association was represented by Drs. Theresa O. Snaith and O. W. Corder, of Weston. Participants included teachers, pediatricians, parents, school principals, supervisors and superintendents, health officers, school and public health nurses, college instructors, dentists, health educators, social workers, sanitarians, and nutritionists.

Mrs. Blanche R. Miller, director of health education of the Anti-Tuberculosis League of Cincinnati and instructor in health education at the University of Cincinnati, and Mrs. Katherine C. Wisely, area home economist, U. S. Department of Agriculture, served as consultants.

The conference followed the group work pattern, the participants meeting small groups to discuss problems confronting them in school health programs.

Several recommendations were adopted by the conference, including matters relating to organization and administration, pre-service, and in-service training.

Among other things, the conference recommended that the county superintendent and school principals establish policies and procedures for health instructions as a part of the total school program; that a health coordinator be appointed for each school on a county level; that a school health council be established in each school; that school health services be extended through the use of available voluntary and professional groups in the county; and that all health departments be encouraged to employ one or more health educators to serve in an advisory capacity for schools.

The conference also recommended that separate workshops and working conferences for all school personnel in their various fields of specialization be held on school time to provide an understanding of and appreciation for a total school health program; that the University and state colleges be advised of the need for evening, extension and summer courses for teachers, and, further, of the need for short courses for non-teaching personnel. It was further recommended that school health programs be provided for all school personnel, including pupils, teachers, administrative staff, janitors, bus drivers, and food handlers.

Before adjournment it was tentatively agreed that the third annual conference will be held at Jackson's Mill sometime during the summer of 1951.

TB DETECTION BY TUBERCULIN TESTS

More than 95 per cent of cases of significant tuberculosis can be detected by use of the proper tuberculin tests, although a negative reaction does not completely eliminate the possibility of the presence of this disease. —Geo. B. Stilwell, M. D., in Proceedings, Staff Meetings of the Mayo Clinic.

RELOCATIONS

Dr. George O. Nelson, of Nitro, who has served for the past five years as plant physician for American Viscose Corporation and Monsanto Chemical Company, has accepted appointment as assistant to Dr. Thomas N. Nale, Medical Director of Carbide and Carbon Chemical Corporation, New York City. He will move to his new location early in October and will have offices at 30 East 42nd Street, New York City.

Before coming to Charleston, Doctor Nelson held a position as Medical Director at the Ordnance Works at Radford, Virginia.

* * * *

Dr. James D. Spencer, who has been located in Florida for the past two years, has located at Mill Creek where he will engage in general practice. Before locating in Florida, he had served for seven years in the medical corps of the Army.

He is a native of Mannington and received his M.D. degree from the University of Tennessee College of Medicine.

* * * *

Dr. Melvin E. Lea, member of the surgical staff of the Myers Clinic, in Philippi, has accepted a position on the staff at Colon Hospital, Cristobal, Panama Canal Zone. He left the first of September to assume his new duties there.

Doctor Lea has been a member of the surgical staff at the Myers Clinic for nearly four years. He came there following three years' service in the Medical Corps of the Army.

* * * *

Dr. Edmund O. Gates, of Welch, has moved to St. Joseph, Michigan, where he will continue the practice of his specialty of EENT. He has offices at 505 Pleasant Street in that city.

* * * *

Dr. George R. Mullins, of Logan, has moved to Wheeling, where he will continue the practice of his specialty of EENT, with offices at 720 Central Union Building in that city.

GP ACADEMY SPONSORS FALL MEETINGS

A joint meeting of the West Virginia Academy of General Practice with the Harrison County Medical Society has been arranged for October 5, at the Clarksburg Country Club. Prominent speakers will discuss obstetrics and neurosurgery.

Another meeting sponsored by the Academy will be held in Bluefield November 12. The program has not yet been arranged.

The Kanawha area meeting sponsored by the Academy and arranged during the summer is being held at Charleston as this issue of the Journal goes in the mails (October 1). The speaking program is being sponsored by the West Virginia Cancer Society.

Dr. Gustavus A. Humphreys and Dr. Robert J. Booher, members of the staff of the Memorial Hospital, New York City, are the guest speakers. Doctor Humphreys is speaking on the subject of "Cancer of the Genito-Urinary Tract," and Doctor Booher's subject is "Cancer of the Gastro-Intestinal Tract."

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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

OBITUARIES

PARIS LEONARD GRAY, M. D.

Dr. Paris Leonard Gray, 60, of Elkins, died unexpectedly at his office in that city September 8, 1950. Death was attributed to a heart attack.

Doctor Gray was born at West Union and received his early education in the public schools at Elizabeth. He received his M. D. degree from Maryland Medical College, Baltimore, in 1911, and was licensed to practice in West Virginia that same year.

Doctor Gray served for three years as a member of the medical staff at the Weston State Hospital. He had been engaged in active practice at Elkins since 1936.

He served as city health officer at Elkins, 1920-26, and at the time of his death was head of the Elkins-Randolph Health Department, which was set up in 1949. Doctor Gray was a member of the Barbour-Randolph-Tucker Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Besides his widow, he is survived by three daughters, Mrs. Robert Kell, of Columbus, Ohio; Mrs. James Ashley, of Mansfield, Ohio; and Mrs. Carlos de Andra, of Mexico City, Mexico; two sons, Randolph Snyder Gray, of Mansfield, Ohio; and Paris Leonard Gray, Jr., of Miami, Florida; and a stepdaughter, Mrs. F. L. Brown, of Corpus Christi, Texas.

* * * *

ELMER GRAVES KESSLER, M. D.

Dr. Elmer Graves Kessler, 64, of Williamsburg, died September 1, 1950, in a hospital at Ronceverte, following an extended illness.

Doctor Kessler received his M. D. degree from Eclectic Medical College, Cincinnati, in 1910, and was licensed to practice in West Virginia that same year. He was a former member of the Greenbrier Valley Medical Society, the West Virginia State Medical Association, and the American Medical Association.

He is survived by his widow, Mrs. Hazel Nunley Kessler; two daughters, Mrs. Alice Marabelle, of Baltimore, and Miss Joan Kessler, of Williamsburg; two sons, John and E. G. Kessler, Jr., of Williamsburg; two sisters, Mrs. Etta Judy, of Williamsburg, and Mrs. Lula Harrah, of Great Falls, Montana; and two brothers, Ray, of Beckley, and Walter Kessler, of San Francisco.

* * * *

GEORGE WILLIAM SPEED, M. D.

Dr. George William Speed, 42, of Mullens, died September 10, 1950, in a hospital at Beckley following several months' illness. Death was attributed to a liver ailment.

Doctor Speed was born in Rochester, New York. He received his A. B. degree from Wittenberg College

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in 1930 and his M. D. degree from the University of Cincinnati College of Medicine in 1934. He was licensed to practice in West Virginia in 1936.

He served for four years in the Army Medical Corps, being discharged with the rank of lieutenant colonel. He was on the staff of Madison General Hospital in Madison until 1949, when he moved to Mullens. He was a member of the staff of Mullens General Hospital at the time of his death.

Doctor Speed was a member of the Wyoming County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

INCIDENCE OF DIABETES

Diabetes occurs at all ages from infancy to old age, but the most cases occur in the older age groups. The younger the patient, the more difficult is the management of diabetes; the older the patient, the less management is required.

It is estimated that there are now about 2,000,000 cases of diabetes in the United States—an incidence of about 1½ per cent of the general population. The incidence of diabetes is highest in areas where the urine of the inhabitants is most frequently examined, and where the inhabitants live the longest and weigh the most. It is believed that mass surveys would reveal about the same incidence in all parts of this country.—W. B. Hunter, M. D., in N. C. Med. J.

COUNTY SOCIETIES

KANAWHA

Dr. C. Marshall Lee, Jr., Assistant Professor of Surgery at the University of Cincinnati College of Medicine, Cincinnati, was the guest speaker at the regular monthly meeting of Kanawha Medical Society held September 12, at the Daniel Boone Hotel in Charleston. His subject was "The New Concepts in the Treatment of Megacolon."

At the business meeting following the scientific session, the following doctors were elected members of the Society:

Samuel S. Shorter, Ward; Elliot M. Namay, Eskdale; George R. Rosenbaum and William C. Cook, Jr., Charleston, both by transfer from the Richmond Academy of Medicine, Richmond, Virginia; Henry C. Huntley, Charleston, by transfer from Lenawee County Medical Society, Tecumseh, Michigan; Benjamin M. Drake, Charleston, by transfer from Rockingham Medical Society, Madison, North Carolina; J. Dennis Kugel, Charleston, by transfer from Cook County Medical Society, Chicago, Illinois; and John H. Bergman, Clay, by transfer from Los Angeles County Medical Association, Los Angeles, California.—Robert C. Bock, M. D., Secretary.

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Announces Continuous Courses

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting October 23, November 27.
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting October 9, November 6.
Surgical Anatomy & Clinical Surgery, Two Weeks, starting October 23, November 20.
Surgery of Colon & Rectum, One Week, starting October 16, November 27.
Breast & Thyroid Surgery, One Week, starting October 2.
Thoracic Surgery, One Week, starting October 9.
Gall-Bladder Surgery, Ten Hours, starting October 23.
Fractures and Traumatic Surgery, Two Weeks, starting October 9.
GYNECOLOGY—Intensive Course, Two Weeks, starting October 23.
Vaginal Approach to Pelvic Surgery, One Week, starting November 6.
OBSTETRICS—Intensive Course, Two Weeks, starting November 6.
MEDICINE—Intensive General Course, Two Weeks, starting October 2.
Gastro-enterology, Two Weeks, starting October 16.
Gastroscopy, Two Weeks, starting October 23.
Electrocardiography & Heart Disease, Four Weeks, starting October 2.
DERMATOLOGY—Formal Course, Two Weeks, starting October 16.
Informal Clinical Course every two weeks.
CYSTOSCOPY—Ten Day Practical Course every two weeks.
PEDIATRICS—Informal Clinical Course every two weeks.

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BOOK REVIEWS

DISEASES OF THE HEART—By Charles K. Friedberg, M. D., Associate Physician Mt. Sinai Hospital, New York City, and Lecturer in Medicine at Columbia University. Pp. 1081, with 79 figures. Philadelphia and London: W. B. Saunders Co. 1949. Price $11.50.

This is a most comprehensive and complete book of heart disease completely annotated and excellently indexed for reference use. It is, however, a book for the student of medicine rather than for the medical student, and each phase of heart disease is discussed from the viewpoint of pathologic physiology as well as from an etiologic classification.

There are ten chapters dealing with heart failure and shock. Each phenomenon is explained in the light of the causative mechanism as well as the application of clinical diagnosis and management. There are eight chapters on circulatory disturbances of the heart and coronary artery disease, and three chapters deal with rheumatic fever and rheumatic heart disease.

There is a complete discussion of the rarer heart disorders including lipochromatosis and other metabolic disturbances with cardiac manifestations. Traumatic heart disease is also well covered along with the cardiac risk in anesthesia and the insurance, medical, and legal aspects of heart disease.

In the light of the author's most extensive and thorough discussion of organic heart disease, the section on benign or functional heart disorders is perhaps a little too brief, but as a whole, this most refreshing book on heart disease will rank as one of the best available to the doctors of today.—John E. Stone, W. D.

* * * *

THE MERCK MANUAL OF DIAGNOSIS—Eighth Edition. Pp. 1592. Merck & Company, Inc., Rahway, New Jersey. 1950. Price $4.50; thumb-indexed $5.00.

Dedicated to the Doctor of Medicine and to his colleagues and aides in the Allied Professions is the Merck Manual of Diagnosis and Therapy which is now available in its eighth edition. This small, compact, pocket-size, source of ready reference for the physician is a must in the busy physician's office and car.

The eighth edition is a completely new handbook, not a revision of previous editions. Thus, the phenomenal advances in medical research and practice of the past few years have been reflected in the broadened scope of the new manual. Outstanding features of this small handbook are:

338 chapters on disease and major symptoms (82 more than in the previous edition);

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This manual is not intended to take the place of standard textbooks, but is probably the most concise, and complete medical reference book available today.

Any general practitioner can remember many middle-of-the-night situations where the Merck Manual would have been an invaluable assistant had one been available.

It's a must in every doctor's library.—Carl B. Hall, M. D.

* * * *

BREAST DEFORMITIES AND THEIR REPAIR—By Jacques W. Maliniac, M. D., Clinical Professor of Plastic Reparative Surgery and Associate Plastic Reparative Surgeon, New York Polyclinic Medical School and Hospital, New York City. Pp. 193, with illustrations. Grune & Stratton, Inc., 381 Fourth Ave., New York City. 1950. Price $10.00.

The new book, "Breast Deformities and Their Repair" by Jacques W. Maliniac, M. D., has been designed to serve as a ready reference and guide to those surgeons interested in mammaplastic surgery. It is profusely illustrated with pictures, diagrams, and drawings so that the reader is taken through the various available procedures step-by-step.

All the available modern procedures for correction of breast deformities are discussed and compared so that the surgeon may determine the proper method for each individual case. A particular method is recommended only if it preserves all possible function of the breast and reproduces its normal form. Critical evaluations are based on anatomic, physiologic, and esthetic considerations.

The author has not neglected the folklore and history of mammaplastic procedures nor the anatomy, embryology, and physiologic development of the breast, several interesting chapters being devoted to these subjects. Each chapter is well documented with references to aid the reader to perform more extensive research if he desires.

The reviewer enthusiastically recommends this book as a valuable asset to all surgeons interested in performing mammaplastic procedures.—Melvin E. Lea, M. D.

* * * *

A TEXT-BOOK OF X-RAY DIAGNOSIS (American Edition). Volume IV—Bones, Joints and Soft Tissues. By British Authors. Edited by S. Cochrane Shanks, M. D., Director, X-Ray Diagnostic Department, University College Hospital, London, and Peter Kerley, M. D., Director, X-Ray Department, Westminster Hospital, London, with fifteen distinguished collaborators. Second Edition. Pp. 592, with 553 illustrations. Philadelphia and London: W. B. Saunders Company. 1950. Price $15.00.

The merited popularity of this comprehensive work is shown by the fact that the first edition has been reprinted six times in the last two years. The editors point out that the rapid progress in radiology should have produced a revision sooner, but this was delayed due to World War II.

In the present volume the normal bones and joints are first considered, together with those variations which are within normal limits and the congenital anomalies and malformations. Two chapters follow on

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the general pathology of bone, and these provided the ground work for extended consideration of traumatic, inflammatory, nutritional, metabolic, endocrine, toxic and other bone pathology and including tumors and cysts and abnormal calcifications and ossifications in the soft tissues. A chapter is appended on the localization of foreign bodies.

The sections are well written in concise phraseology and the coverage is ample for the clinician who is not interested in the more detailed monographs, and is also ample as a work-a-day reference for the busy radiologist. The bibliography is extensive.

The illustrations are positives but have in general unusually good detail.

Originally published as a three volume set, the second edition is to have four volumes. This has been made necessary by the additional subject matter and the lengthening of many of the revised sections.

It is a work that we feel should be in the hands of every radiologist and every clinician who is interested in x-ray diagnosis.—Karl J. Myers, M. D.

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ACAA TO MEET OCT. 8

The organization meeting of the American College of Clinic Administrators, a West Virginia Corporation, will be held at the Greenbrier Hotel in White Sulphur Springs, October 8, immediately preceding the annual meeting of the National Association of Clinic Managers, scheduled for October 9-11.

The following were named as incorporators in the charter: Drs. Robert K. Buford, Charleston; Robert J. Wilkinson, Huntington; Hu C. Myers, Philippi; Herbert Acuff, Knoxville, Tennessee; and Mr. Robert J. Wilkinson, Jr., Huntington. Doctor Buford is acting president of the new organization, and Mr. Wilkinson, the acting secretary.

DR. J. R. BROWN CALLED TO ACTIVE DUTY

Commander James R. Brown, MC (USNR), of Huntington, has been called to active duty in the Navy, and is stationed at the U. S. Naval Hospital at Pensacola, Florida. He served in the Medical Corps of the Navy for over three years during World War II, being released in November, 1945.

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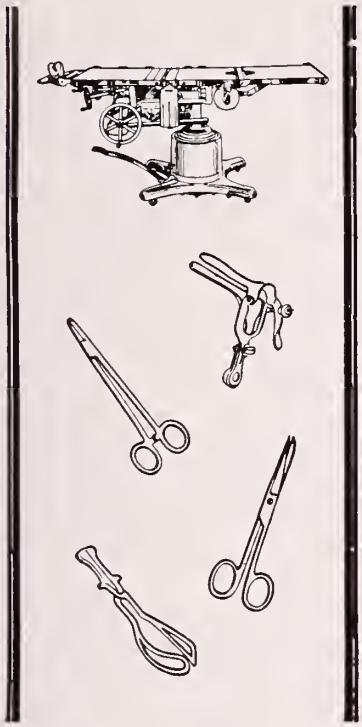

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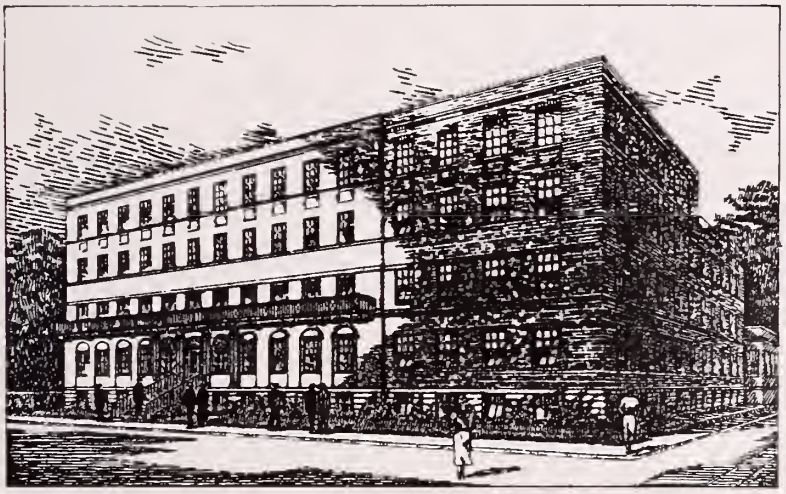

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WOMAN'S AUXILIARY

EXECUTIVE BOARD MEETING

The fall meeting of the executive board of the Woman's Auxiliary to the West Virginia State Medical Association will be held at the Daniel Boone Hotel in Charleston, October 3, 1950. The meeting will be called to order at 10:00 A. M.

The members of the board attending the meeting will be the guests of the Auxiliary to Kanawha Medical Society at a luncheon which will be served at 12:15 o'clock.

KANAWHA

The first meeting of the fall season was held by the Woman's Auxiliary to Kanawha Medical Society at the home of Mrs. A. A. Wilson, in Charleston, September 12.

Mrs. Pat A. Tuckwiller, the president, presided at the meeting, and the program for the year was presented and discussed. Special projects to be continued during the new year include aid for the city-county health clinic, providing clothing for school children upon the recommendation of the Department of Public Assistance, furnishing the Cancer Closet for the Visiting Nurses' Association, and aiding the State and National Nurse Recruitment Program.

Scholarships of one hundred dollars each were presented to Miss Eva Selbe and Miss Ruth Bulmer by Mrs. Edwin M. Shepherd, chairman of the Nurse Recruitment Committee. The awards were made upon the recommendation of a committee composed of a doctor, a district nurse supervisor, and a member of the Auxiliary. Awards were made on the basis of scholarship and other outstanding qualifications.

Small personal awards were also made to Miss Marion Spangler and Miss Ann Compton, the two nurses who received scholarships in 1949.

The meeting was attended by over seventy members of the Auxiliary. Mrs. Thomas G. Reed was chairman of the hostesses for the afternoon. She was assisted by Mesdames John P. Brick, Harry Carney, Bert Bradford, Jr., J. Paul Aliff, John E. Lutz, Harry E. Baldock, E. B. Henson, George P. Heffner, Carl Ferris, and A. B. Curry Ellison.—Mrs. John C. Condry, Corresponding Secretary.

ANNUAL PICNIC IN CABELL

The annual picnic of the Cabell County Medical Society and Auxiliary was held Thursday, August 31, 1950, at the Huntington Police Recreation Center. The picnic, which was in the form of a Bar-B-Q, was attended by more than 150 members of the Society, Auxiliary, and guests.

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VACATION A "MUST"

Doctors often tell their patients to slow up or they may fold up. We also laugh at the Irishman who, when ordered "Money or your life," said, "Take me loife; Oi'm savin' my money fer me auld age."

Too many of us are saving up, money and leisure relaxation, for an old age that we may never attain. One characteristic of a medical practice is that we are never "off duty" so long as we are within reach of our patients. We eat, sleep, work, go to lodge, church or theatre with one ear tuned for the telephone. There is no "end of the day" or free week-end for us unless we do actually get out of reach of our patients. This feeling is not for the money involved nearly as much as it is for the feeling of obligation we have for our patients. We feel that someone might need us, and so are living constantly under tension and fully "wound up."

We owe it to ourselves and to our patients to relax and get unwound at not too infrequent intervals. We can do better work for them when we are refreshed and renewed by some time off from the demands of that telephone bell, whether it be by attending a scientific session somewhere, or by going fishing. Mental work is more fun to a rested mind, and the results are better. And what's more, you will probably live longer. Look at the obituary pages of the AMA Journal and note the ages of death and the number of them that are coronary.

It is time for us to wake up to the fact that we are individually our own best patients, and to treat ourselves somewhat like our other patients are treated. Prescribe for yourself an absorbing hobby into which to escape your tension, and rest in the form of attending meetings and taking vacations at frequent intervals. —L. J. Pankow, M. D., in South Dakota J. Med. & Phar.

QUALITY IN MEDICAL CARE

Unquestionably, the advocates of tax-supported medical care honestly believe that service of a consistently high quality can be furnished to all segments of the population at a reasonable cost. They must believe also that this method of distributing and financing medical service will not continue beyond a generally acceptable limit, and that the evolution of a democracy into a service state will not continue until many personal liberties have been suspended.

The honest opponents of a national tax-supported health program on their part, want proof that such a plan will not deteriorate into a system of politically controlled medical practice.

Overfearful, perhaps, they still require some sign that man's capacity for political leadership has really risen to the point where honesty and intelligence will remain constantly at the helm, before they relinquish the checks and balances, clumsy as they are, that a system of individual enterprise provides. It appears to many that there is as yet no better sign than there has ever been that mediocrity, indifference and extravagance will no longer be factors in a system based on bureaucratic control.—New England Journal of Medicine.

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No discovery has supplanted or seems likely to supplant proper dietary advice from its place of first importance in each of our diabetic problems. We must continue to try to show the newly discovered diabetic why it is necessary he live within the realm of his food tolerance. We still need to show him that he may live so nearly like his fellow man that his greater sense of well-being will more than compensate for his care in the selection and quantity of his food intake.—W. A. Thornhill, Jr., M. D., in Bull, W. Va. Dietetic Assn.

Studies of the coincidence of pulmonary scarring or calcified nodules and histoplasmin skin sensitivity in tuberculin-negative persons have emphasized that lesions which in the past would have been interpreted as tuberculosis in origin may be the result of an infection with histoplasma capsulatum or some other related organism.—Samuel Saslaw, M. D., and Charlotte C. Campbell, Am. J. Ph., April, 1950.

BLUE CROSS - BLUE SHIELD COMMITTEE

Drs. James S. Klumpp, of Huntington, Frank V. Langfitt, of Clarksburg, and Athey R. Lutz, of Parkersburg, have been named by Dr. Thomas G. Reed, chairman of the Council, as members of a committee to study the feasibility of unification in the administration of the various Blue Cross and Blue Shield organizations in West Virginia. Doctor Klumpp will serve as chairman of the committee, which has been appointed by Doctor Reed under authority granted to him at the pre-convention meeting of the Council at White Sulphur Springs, July 26.

W. VA. TB AND HEALTH ASSOCIATION ELECTS

Mr. Paul M. Lowther, of Clarksburg, was elected president of the West Virginia Tuberculosis and Health Association at the 13th annual meeting in Bluefield, September 20-21. He succeeds Dr. W. L. Cooke, of Charleston. Other officers were named as follows:

Vice president, Karl J. Myers, of Philippi; secretary, Dr. H. H. Howell, of Madison; and treasurer, Mr. Robert C. Hawkins, of Charleston (reelected).

Drs. William L. Cooke, W. P. Bittinger, of Summerlee, Mr. P. N. B. Hampton, of Huntington, and the Rev. Winton Houck, of Charleston, were elected members of the executive board.

Mr. Edmund P. Wells, of Augusta, Maine, executive secretary of the Maine Tuberculosis Association, and former secretary of the West Virginia TB and Health Association, was the guest speaker at the annual banquet.

CHESTNUT LODGE ROCKVILLE, MARYLAND

In addition to its current psychotherapeutic program, Chestnut Lodge now offers facilities for the care, study, and treatment of the elderly patient requiring psychiatric supervision.

Accommodations are available for thirty patients, either in private or two-bed rooms with adjoining bath in a newly constructed building, specifically designed for the senile patient.

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BEST CANCER DETECTION CENTER

We can learn a lesson from our dental friends. The public, one and all, know they are supposed to see the dentist twice a year. No propaganda about abscesses, tumors, hare lips, pyorrhea, or other bugaboos, just see the dentist twice a year.

Why not the same approach for the rest of the body, no horror stories, or partial case histories. Let's get Americans to see their doctor once or twice a year, just that, check with your doctor; he is your best cancer detection center and your best heart station.

We will prevent the development of millions of neuroses by emphasizing the need of a yearly or semi-yearly check-up, and forget the specific diseases. We can catch them in a history and physical, not in the newspaper.—C. P. P. in Bull, Columbus Acad. Med.

OUR BOTTOMLESS (?) TREASURY

In our population there are politicians, visionary theorists, unpractical experimenters and cranks who are always ready to tell able and experienced men how to run their own profession. In our own profession, we have failures or guillible fellows who join with them in advocating control of the professions, and who preach the great idea that the government owes the citizen economic and social security—just as a parent owes these to his children.

When the medical profession of Great Britain rejected compulsory health insurance, economic pressure was brought to bear, and a total surrender of freedom was required of the medical profession in Great Britain. After one year's experience, the medical profession is not any too happy about it.

According to William Alan Richardson, editor of Medical Economics, who recently returned from England, Wales and Scotland where he directed a month-long on-the-spot study of the British experiment, "the general practitioner in Britain is faced with this paradox: If he has a large list of public patients, he can't give decent service. If his list is small he can't make a decent living."

Great Britain's adventure into socialized medicine has, in one year, done two things: 1. It has changed the physician's livelihood, his professional advancement, and his loyalties have been commandeered by a new master—the government—which pays him with the taxpayer's money; and, 2. It has destroyed the relationship between doctor and patient.—New York Medicine.

CAA LISTS AMBULANCE PLANES

The Civil Aeronautics Administration, Department of Commerce, has prepared and printed a brochure containing a list of ambulance planes by states and a supply has been received at the headquarters offices of the State Medical Association. A copy of the brochure has been mailed to the secretary of each component society, and additional copies will be supplied to persons interested. Requests should be addressed to West Virginia State Medical Association, Box 1031, Charleston 24, W. Va.

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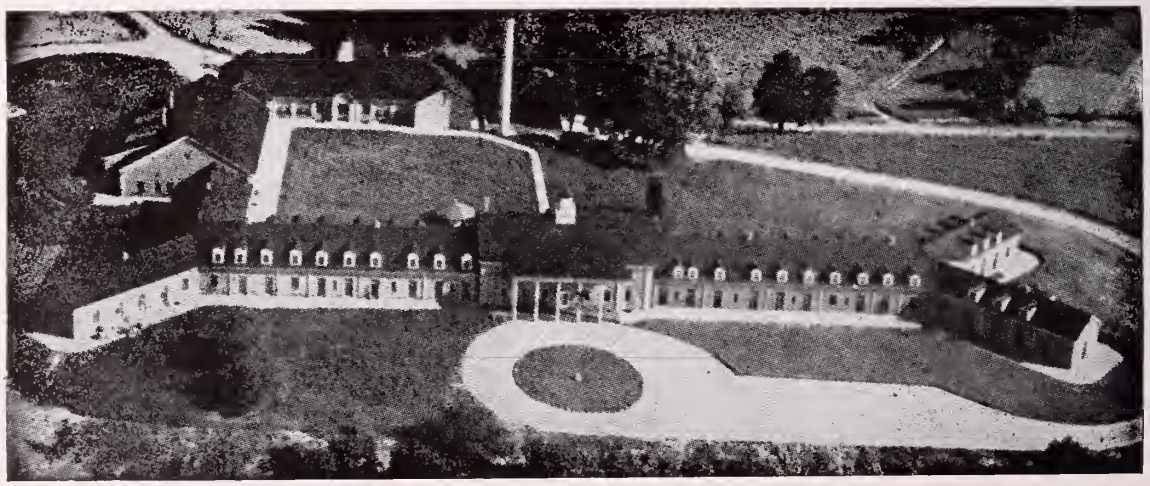

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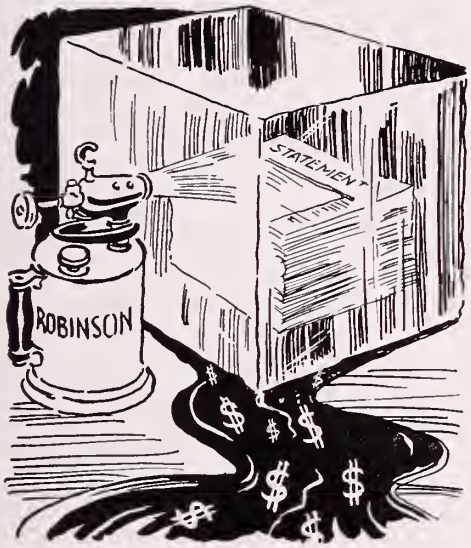

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MEDICAL PRECOCITY

A few days ago while walking to his office the writer was joined by his neighbor's seven year old daughter. As we passed her home, the child's younger sister was playing in the front yard with a hammer and nail. My companion without saying a word snatched the nail away and threw it across the hedge. Nonchalantly she continued the family gossip until we came to lend of the block. When she was ready to turn back I took the initiative and said, "Don't you think it was rude to jerk the nail away from your little sister without saying a word." "Yes, but Mother has told her not to play with nails, and besides it was rusty and she might have to take tetanus shots."

As I entered the elevator on the way to my office, a mother was almost strangled by the frantic grip of the babe in arms as she screamed bloody murder. Apologetically the mother said, "She knows you are a doctor and expects a shot."

Obviously the dissemination of knowledge is not wholly dependent upon Whitaker and Baxter.—J. Okla. St. Med. Assn.

THE AGING HEART

The presence of heart disease inspires fear in anyone and especially in the elderly patient. This is to be expected, since heart disease kills so many people and often causes sudden death. However, fear and worry decrease cardiac efficiency and add to the burden of the disease. Attacks of anxiety-hysteria may also complicate the diagnosis of heart disease. These must be differentiated from paroxysmal nocturnal dyspnea since different treatment is demanded in the latter case. The latter may require salt restriction, digitalization or mercurial diuretics; the former requires psychotherapy or sedation.

An optimistic outlook must be presented to the patient as an aid to recovery. The recent trend, showing increased longevity after onset of heart failure or coronary thrombosis, justifies this outlook. The possibility of sudden death or short life span may be explained to the family, but harm will result if the patient worries excessively.—Paul Kaufman, M. D., and Harvey Poliakoff, M. D., in Geriatrics.

FILL YOUR CHURCHES

Returning home from our vacation in Northern Michigan last month we passed a small country church on the bulletin board of which was the following notice: "Fill Your Churches, Fill Your Arsenals." I know of no better advice for the present time.

We physicians, Protestant, Catholic or Jew, should go to Church and implore our merciful God to preserve the peace and spare our fellow men suffering and death. We should pray daily for our fellow man.

We should counsel our leaders in government to fill our arsenals that we may defend our beloved homeland and our freedom.—C. P. P. in Bulletin, Columbus Academy of Medicine.

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DISASTER?

Disasters may be of many kinds—personal, physical, moral, political, or economic. Some kinds are preceded by warnings; for example, the rumblings which usually precede the eruption of a volcano; others strike suddenly and silently. Are we physicians on the verge of some sort of disaster? Have we for long disregarded the warning signs and portents?

The entrance of government into the medical field has large implications of disaster. These are mainly political and have probably been underestimated as to their importance. More and more during recent decades the individual has become subordinate to the state; the citizen's coming and going has been and will be increasingly supervised by a supreme order. To the state he must contribute his wherewithal but is permitted little or nothing to say about its disposition.

Propaganda for government-controlled tax-supported medical care promising everything "for free" is increasing in intensity. Both Federal and state legislation to that dubious end is before Congress and various state legislatures. Much of it promises what, with present or forseeable facilities, cannot be performed with the best of intentions even under the lash of compulsion. Yet the citizens are being asked to trade their birthright of individual initiative and their self-respecting structure of free enterprise for this sorry mess of tax-supported pottage which is anything but "free."—N. Y. State J. Med.

A PERSONAL CODE OF HONOR

The profession of medicine is a noble one and its members subscribe to Codes of Honor which prescribe the finest ethical standards of service to mankind, namely The Hippocratic Oath and the A. M. A. Code of Ethics.

It appears that a physician is most effective when he not only lives up to these codes, but also conceives it his duty through his community consciousness and awareness of the problems of public health matters to dedicate himself to the objective of a rather more personal Code of Honor.

This dedication is outside the realm of private practice and is a voluntary committment for employment of one's interest, advice, and counsel, even leadership in community, state and national health programs.

We affirm that all of us, even though restricted by a busy practice, should devote to a greater or lesser degree time, thought and effort to local problems of public health. Our usefulness in such matters is so much sought and appreciated. The problems are myriad, such as sanitation, pollution, crowded living conditions, spread of contagion, mental health, nutrition, child welfare, etc.

The Doctor cannot furnish the formula for a panacea that will thwart all threats to health, but certainly he can greatly assist in reducing the spread and virulence of those threats.—Charles H. Sprague, M. D., in Connecticut State Medical Journal.

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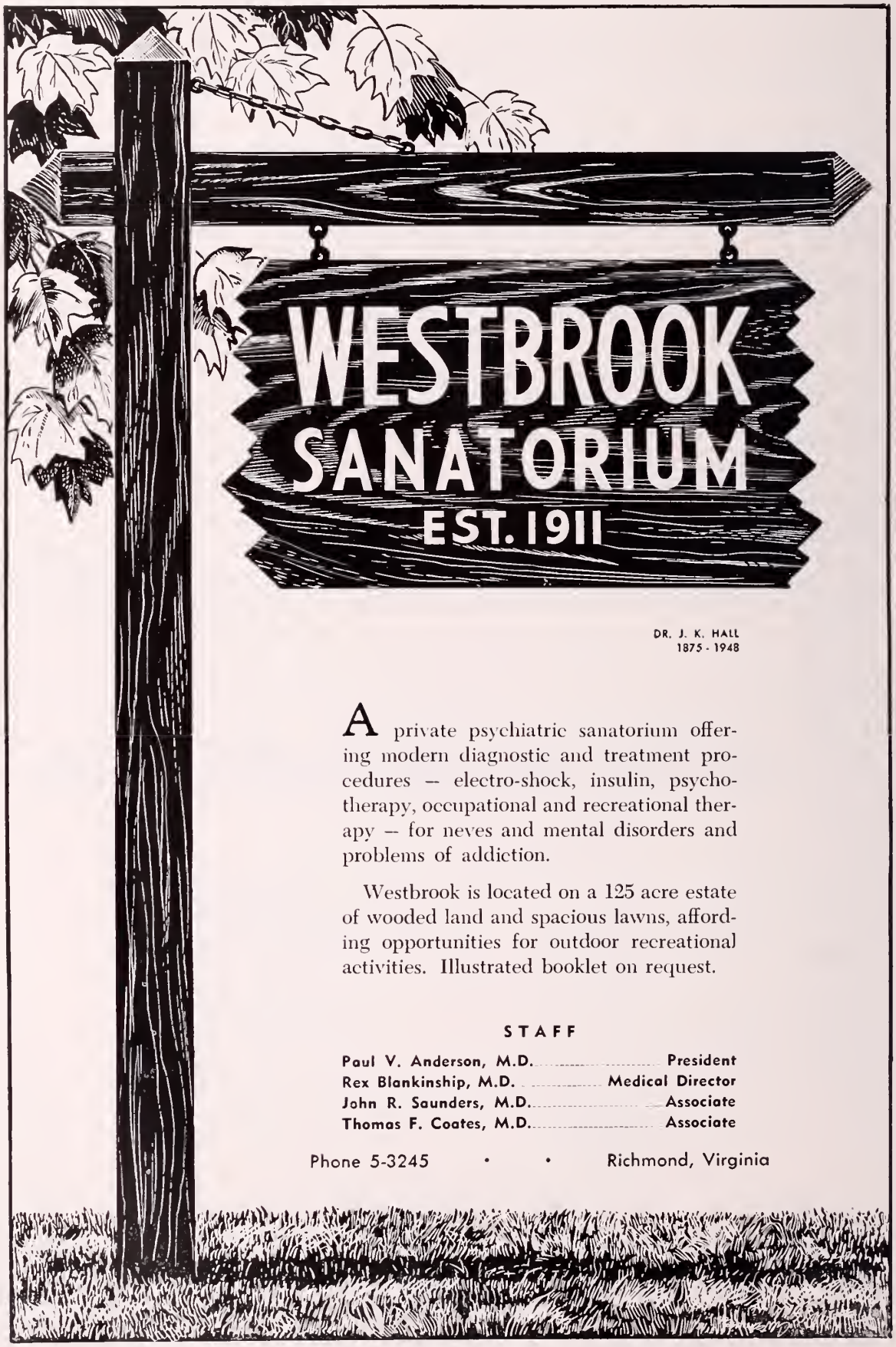

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WALTER E. VEST, M. D.
955 Fourth Ave.
Huntington, W. Va.

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Business Manager
MR. CHARLES LIVELY
Box 1031
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REPORT OF RURAL HEALTH SURVEY IN ROANE COUNTY*

By GERTRUDE HUMPHREYS,
State Leader, Home Demonstration Work,
Agricultural Extension Service,
West Virginia University,
Morgantown, W. Va.

What do rural people think of their present health and medical care facilities and services? What do they consider their major health and medical care problems? These are questions that have been raised from time to time at State Rural Health Conferences and at other West Virginia meetings where rural health has been discussed.

The idea of making a spot survey to find some of the answers grew out of a rural health meeting held at the State 4-H Camp, Jackson's Mill, on September 22, 1949. As this meeting, called by the public relations committee of the West Virginia State Medical Association, were representatives of the State Department of Health, the School of Medicine of West Virginia University, the Farmers Home Administration, the Parent-Teachers' Association, the Farm Bureau, the Farm Women's Council, and the Agricultural Extension Service, in addition to members of the State Medical Association.

The consensus of this group was that in the development of a constructive health program, as much information as possible should be obtained in regard to rural health facilities and services from the viewpoint of the rural people. Therefore it was suggested that one way to begin this search for consumer opinion was to make a survey in a typical rural county. The responsibility for it was given to representatives of the Agricultural Extension Service.

After consultation with representatives of the state agencies and organizations actively participating in the rural health program, and also with out-of-state professional workers who have had experience in conducting health surveys, a survey form was prepared and mimeographed.

The selection of Roane County as the area in which to make the survey was given much consideration. Rural counties were compared and discussed from the standpoints of income, roads, health services now available, and general living conditions. It seemed desirable to select a county that was typical of rural areas throughout the state, not the best nor the poorest. Organizations through which to work in making the survey had to be considered, as well as the interest of rural people in their health problems. In the light of these requisites, Roane County was selected.

The survey idea was suggested to the Roane County Extension workers. They were interested and felt that the rural people would be. They called a meeting of representatives of rural organizations and of the agencies working in rural areas. No medical nor other professional groups were invited, only those having local leaders through whom to work in rural communities. Attending this meeting were representatives of the Farm Women's Council, the Farm Bureau, the Veterans on-the-Farm Training Program, the Farmers Home Administration, the County Agricultural Agent, the Home Demonstration Agent, and the 4-H Club Agent. After a thorough discussion of the purpose of the survey and suggested procedures in conducting it, the group voted unanimously to assume responsibility for

*Presented before the Rural Health Conference sponsored by the public relations committee of the West Virginia State Medical Association and held at Jackson's Mill, May 18, 1950.

making it in Roane County. Plans were outlined at the time for the part that each organization and agency would have in reaching families in all sections of the county without duplication of effort or overlapping of territory.

Most of the work was done through the 20 farm women's clubs in the county, under the guidance of the home demonstration agent. At the March 1950 meetings, club members filled in the survey forms, and each member took forms for as many non-member neighbors as she felt she could see and interest in giving the information called for on the survey form. The same plan was used for the Veterans on-the-Farm Training classes, especially in sections of the county not reached by farm women's clubs. Farm Bureau members and 4-H club leaders were responsible for getting information from families and from areas not reached by the other organizations.

The survey form was filled in by 300 families representing all areas of the county but in no sense of the word can it be called a scientific study. The selection of families was not done on a scientific basis, and the forms were not filled in by trained interviewers. Because of this the findings cannot be applied generally to the entire population of the county, or of the state. The results do indicate, however, the opinions of some rural people regarding their health problems and needs.

Most of the families who filled in the survey form were full-time farmers but, as is true in most West Virginia counties, many farm families get part of their income from sources other than the farm. The summarized report of the 300 families included in the survey shows that

59% were full-time farmers
27% were part-time farmers
7% were not farmers
7% did not fill in this part of form

The majority of the farmers were farm owners

76% owned their farms
15% were renters
9% did not indicate

The questions of the survey were grouped under six main headings: (1) Doctors, (2) Hospital and Clinic Facilities, (3) Nurses, (4) Dentists, (5) Prepayment Plans for Hospital and Medical Services and (6) Public Health Services.

Doctors:

In answer to the question, "Did you have the services of a doctor in your home during the past year?"

33% replied *yes*
67% replied *no*

In the homes having a doctor, there was an average of 2-1/3 visits per family.

Of the families not having the services of a doctor, 34% reported that they had no illness and had not needed a doctor.

Of the other 101 families who did not have a doctor, the reasons given were:

25% said no doctor was available
11% said they could not get a doctor when he was needed
10% said the doctor refused to come
Reasons: "too busy," "distance to great," "roads too bad," "reason unknown"
31% said they didn't try to get a doctor. Some of these said there was no use to try — roads too bad for him to travel over
The others gave reasons such as, "We go to the doctor because he is too busy to come to us." "No use to waste time and money — he said he couldn't do us any good."

The question was asked, "Do you think your family has had satisfactory medical care during the past year?"

76% answered *yes*
11% answered *no*
6% *didn't know*
7% *did not reply*

The reasons given by those who thought they had not had satisfactory medical care were:

No doctor within easy reach
Cost too high, or didn't have the money even for reasonable fees
Roads impassable part of the year; one said the doctor would have to walk 2½ miles each way
Lack of telephone service when doctor is needed
Doctors too busy in office to make trips to the country

Roads play an important part in rural health.

The distances from their family doctors varied from one mile of hard-surfaced road to 36 miles, or even to 50 miles for families depending on doctors from other counties. Many of the families live where they have to travel seven and eight miles over unimproved dirt roads which are almost impassable during the late winter and early spring.

13% of those reporting were 25 or more miles from their family doctor
34% were from 15 to 24 miles away
30% were from 10 to 14 miles away
21% were less than 10 miles away
2% did not report the distance

Approximately one-fifth (19%) of the families had to travel three or more miles over dirt roads to get to a doctor, and 36% had to travel over more than one mile of dirt roads.

Reports on the approximate age of their family doctors show that

14% of the families depend upon the services of doctors over 70 years old
14% depend on doctors between 51 and 70 years old
21% depend on doctors between 41 and 50 years old
42% depend on doctors aged 40 or under
9% did not report

The usual charge for a home visit of the family doctor varied from $3 to $25. One family living 14 miles from town, 8 miles of which are unimproved dirt road, reported $40.

Costs in the order of the number reporting were:

(1)	$15	(4)	$12	(5)	$ 4
(2)	10		25		6
(3)	5		8		18
			3		20

Charges for office visits varied from $1 to $8, the largest number being $2, with $3 next, and $1 third.

The distance to specialists ran as high as 60 miles; 65% of the families reported that they were 35 or more miles from specialists.

Some of the needs expressed were: more doctors in or near rural communities; more doctors who will make rural calls; more young doctors; more doctors who will use the newest drugs; better equipment and facilities for rural doctors; better roads so that doctors can travel to patients, and patients can be taken to doctors.

Hospital and Clinic Facilities:

Slightly more than 11% of the families reporting are 25 or more miles from a hospital, and 35% are 15 or more miles away.

Only 11% said it is difficult to get admission as a patient; 62% said it is not difficult, and 27% did not know. The amount of advance payment reported ranged from $20 to $50.

A total of 32% of the families reported having members as hospital patients during the year. Four-fifths of these families reported being satisfied with the care received. Approximately one-fifth were not satisfied; they reported crowded conditions, and lack of the necessary attention.

In answer to the question, "Do you think your community has satisfactory hospital and clinic facilities?"—49% said "no." The question, "What is needed most?" brought these replies:

More clinics and better clinic facilities
Larger and better equipped hospitals
Hospitals where all doctors, including doctors from other counties, can bring their patients
Hospitals not owned by a doctor
Community clinics, particularly for the treatment and immunization of children
Hospital facilities for care of the poor
Improved roads so that patients can be taken to hospital

Nurses:

In response to the question, "Can you get a trained nurse when needed in the home?"

11% said *yes*
21% said *no*
68% *did not know*

The cost per day ranged from $8 to $10 for eight hours. For 12 hours, the cost ranged from $12 to $30.

Several expressed the need for more trained nurses, and particularly for more training in home nursing and first aid for rural homemakers.

Dentists:

Approximately 71% of the families reported a distance of 10 or more miles to their dentists, and 10% more than 25 miles. Only 7% said it is difficult to get an appointment; 53% reported being able to get an appointment in less than a week; only 2% said it requires two weeks.

The question, "Have members of your family been to a dentist during the past year?" brought positive replies from 71% of the families. Only 23% thought the family had not had satisfactory dental care during the year. The reasons given for inadequate care were:

Did not try to get appointment
No dentists nearby
Cannot afford the cost
"Just neglect"

Prepayment Plans for Hospital and Medical Services:

Answers to the questions regarding enrollment of the family in prepayment plans show a small coverage of the rural families of the county and a great lack of information about the plans available.

20% report being enrolled in a hospital service plan
Only 4% in a surgical service plan
Only 3% in a medical service plan
Only 8% in a medical-surgical service plan

More than half of these plans of the families reporting cover the entire family. A few of them (about 7%) cover the man only.

Enrollment of the families, according to type of plan, is as follows:

10% (of total number of families—300) are enrolled in industrial or other group plan
7% in Blue Cross, Blue Shield, or other non-profit association
8% in private insurance company plan

Of the families enrolled in prepayment plans, the survey shows that the part-time farmers outnumber the full-time farmers; about 3/5 are part-time, and only 1/4 are full-time farmers. The others do not farm at all. Also, only 1/5 of the families enrolled in the plans are renters.

In answer to the question, "Has your family ever belonged to a hospital or other service plan, and then dropped it?"—17% of the families said "Yes." The majority of the reasons given seemed to fall under these headings:

Cost too high:

"Too expensive for poor man." "Too expensive for benefits received." "Couldn't afford it." "Did not have money to keep premiums paid."

Changed from industrial employment to farming:

"Quit public work." "Stopped working for company." "Dropped when occupation changed." "Had industrial policy—quit job." "Carried till laid off."

Experiences with unscrupulous companies:

"Company dissolved." "Plan folded." "Company no good." "Inadequate." "Hospital in county would not recognize plans." "Company had too many claims." "Company didn't pay claim." "Had to sue to collect."

Personal reasons:

"Neglect." "No longer needed."

It is quite evident from these answers that at least a part of the families in the county have had unfortunate experiences with private insurance company plans, probably the "fly-by-night" variety that are not licensed to practice in the state. It seems also that a number of the families reporting have gone from industry or mining into farming, and that their group prepayment plans were dropped when they made this change. More than three-fifths of the number dropping plans are now full-time farmers, and four-fifths are farm owners.

The question, "If you have not been a member of any prepayment health service plan, why haven't you?" brought reasons such as these:

Lack of knowledge of plans and their availability:

"Not available." "No one explained the various plans." "Never heard of them." "Don't know of any available."

Consider cost too great:

"Can't afford the premiums." "Cost too high in proportion to benefits received." "Have thought it too expensive." "Do not have the money." "Too costly to carry."

Indifference:

"Not interested." "Neglected to take out a policy." "Just didn't." "Just neglect." "Just carelessness.' "We just put it off." "Did not bother to enroll."

No need felt for the service:

"Did not feel the need of it." "Didn't want it." "We never needed it." "Never appealed to me."

One man replied that he considered prepayment plans a waste of money, yet in another part of his report showed that a member of his family had been in the hospital for six months at a cost of $5,000.

The preceding answers indicate the great need for information and study of prepayment plans, also for helping families establish standards by which to judge the available plans.

Public Health Services:

(During the period covered by this survey, there was not a fully staffed public health unit in Roane County. Also this section of the survey was near the end of the form, and in many cases lack of time prevented its being filled in as carefully as other parts.)

Answers to the question, "What public health service has your family used?" showed that about 15% of the families had made use of immunization clinics (smallpox, diphtheria, and typhoid), and also physical examinations for detection of cancer, as well as chest X-rays and dental clinics. Use of public health facilities for testing and

making safe the water supply was reported by only 3% of the families.

Reasons given for not making use of any public health services may be grouped under these headings:

1. Lack of information about the service:
   "Didn't know about them."
   "Did not know it was free of charge."
   "None available."
   "Have no small children."
   "No health nurse available when needed."
2. Indifference:
   "Neglected to do so."
   "Don't think it necessary."
   "Neglect."
3. Bad roads—poor transportation facilities:
   "Too far away."
   "Difficulty in getting to them."
   "No transportation to town on days health office is open."
4. No need felt for the service:
   "We are all in good health."
   "Haven't needed any."
   "Don't need the service."

While this report represents the opinions of a relatively small number of people in only one county of the state, it does bring into focus at least a few of the major rural health problems; also it calls attention to some of the reasons why it is difficult to make available to rural people the kinds of health facilities and services needed for achieving and maintaining optimum health.

ADVICE OF OLDER DOCTORS NEEDED

Life is made up of a series of varying circumstances and multiple adjustments. Without the aid of those experienced in living, no individual would survive the mere process of living a life. This places a special burden upon those members of the human race who are now left to tell the story of their experiences.

The elders in the medical profession are more in a very special way exceedingly valuable to the young men. The embryonic doctor is about as useless in the field of medicine as a fountain pen is without ink, unless he is taught in a practical way the art and science of medicine. The science is ever changing, the art changes but little. The beginner is not possessed of the knowledge of either.

The ambitious youth desiring to study medicine needs from his elders sympathy, encouragement, discipline, financial aid and opportunity. He is almost dependent upon the older doctors for all of these, because under the present system of medical education even though his tuition is paid by some agency outside the profession, this constitutes only a small part of the total necessary to equip him with the proper medical knowledge to make a successful doctor.—R. B. Davis, M. D., in Southern Medical and Surgery.

RURAL MEDICAL FACILITIES*

By GEORGE F. BOND, M. D.,
Valley Clinic and Hospital
Bat Cave, North Carolina

During the past few years there apparently has been a decided trend toward sensible and collective consideration of the whole scope of rural problems. Whereas in the past decade the grievances of the country people were relegated to the yonder pew, and scarcely considered worthy of group action, it has been heartening to see an increase in the rural health conferences which are being held on state and national levels. It is by such action that the situations of our rural population can be properly presented and evaluated; by this means we hope to achieve sensible solutions to the problems. I am poorly qualified to discuss with you the provision of medical facilities for rural areas but if you will bear with me, I will try to outline a few salient questions.

In your own state, the population is about 70 per cent rural, that is, it is composed of people living in communities of less than 2,000, or in outlying isolated farming and mining districts. Because of factors too lengthy for consideration at this moment, these people are, to a large extent, bereft of anything like adequate medical services.

Let us consider some means by which this handicap can be overcome in the state of West Virginia. A solution to this problem is certainly easy to state, however difficult it may be to attain. You need more doctors settled in strategic locations throughout the state, and you need adequate but not elaborate hospital workshops for these doctors in order that they may be attracted to rural locations, be satisfied in their work, and render the maximum service for which they were trained. At present you have not the necessary number of qualified general practitioners to undertake a complete rural program, nor have you provided any facilities which would attract and hold these men. This constitutes your rural health problem.

COMPLETE MEDICAL EDUCATION

I will dispense with the question of doctor shortage as quickly as I can. The shortage, I believe, will resolve itself when you are able to complete the final training of your own medical students, when you are able to offer financial equality, and when you are able to provide adequate facilities in rural areas to modernize medi-

*Presented before the Rural Health Conference sponsored by the public relations committee of the West Virginia State Medical Association and held at Jackson's Mill, May 18, 1950.

cal treatment. There are other factors in the acquisition of qualified general practitioners for rural practice but those mentioned are the major ones which, if adequately provided, will result in enough doctors to provide good rural medical care. I say general practitioners for the obvious reason that none but a general practitioner can adequately manage all of the requirements of a country practice.

Today, I would like to consider at some length the facilities which I believe must be provided for rural practice, and the means by which these facilities can be obtained and maintained.

MODERN FACILITIES NEEDED

Forty years ago, it was not necessary that a general practitioner have instant access to hospital and laboratory facilities in order to provide proper care for his patients. Today, the modern graduate is trained in the hospital type of practice, and can do his most effective work only when he is provided with at least the minimum facilities required for diagnosis and treatment of the conditions which he is qualified to manage. This fact has finally been recognized by medical and lay people alike, but the definition of adequate medical facilities has been arbitrarily stretched to the dimensions of a teaching hospital and shrunk to the size of a room in the doctor's home. A happy medium must be found between these two concepts in order that proper facilities may be available, suitable for the scope of the doctor's work, but not so complicated and expensive as to represent a white elephant and an intolerable burden on the taxable units which support it.

Only recently has the concept of a combined hospital and health center been propounded as an answer to the problem of inadequate rural medical facilities, and even in this field there has been such variance of construction details, personnel requirements, equipment, and general maintenance expenses, that no single functional unit has yet been seen as a working standard.

It is my belief that the most satisfactory health center—hospital combination which could be evolved would be a structure combining regional public health facilities with a small general hospital unit ranging from ten to twenty beds, including offices for local doctor and dentist. In planning the size, location and overall construction of these units, one must not be too greatly influenced by the concepts demonstrated in the design of large teaching hospitals; instead, the unit should be constructed to provide with maximum efficiency exactly the services which will be most required in that area.

RURAL PRACTICE

In rural practice it should be recognized that the doctor will be capable of managing about 85 per cent of all of the medical problems which he encounters, and that he will conscientiously refer the remaining 15 per cent to larger centers where more complete and specialized attention can be given. It would, therefore, be unwise to build a tiny rural hospital in such a fashion that it could care for literally 100 per cent of all patients entering its doors, when the resident physician will not be capable of completely utilizing these facilities.

Let us be more practical. I believe that a well rounded and useful country practice should be made up of one-third public health activities, one-third obstetrics and pediatrics, one-sixth ambulatory and hospital illnesses of the working age group of the area and, finally, one-sixth devoted to the degenerative and medically unresponsive conditions of the older age groups. If this analysis is correct, then we must assume that the general hospital, however tiny, will be adapted for completely satisfactory obstetric and pediatric care. It must have provisions for minor surgery and necessary major surgery, but need not anticipate elective major surgery which could be done better elsewhere. It must have bed capacity to provide for hospitalization of the younger age group within this area in case of severe illness, and should be equipped for the management of accidents and acute medical emergencies of the working age population.

It is unfortunate that very little actual hospital space can be planned for the care of long term geriatric cases or for the hospital management of hopeless degenerative diseases, which would throw a great strain on the nursing and technical staff of the institution; but this is not the function of a rural hospital. It is important that facilities be found within the building for outpatient visits which would constitute the private practice of the physician of that area, with all x-ray and laboratory facilities instantly available to this doctor's outpatient clientele.

PREVENTIVE MEDICAL SERVICES

I cannot place too much emphasis on the necessity of proper preventive medical services to be provided by this unit. If we are thinking of raising our local health standards literally by the bootstraps we must remember that one-third of all infant and pediatric illnesses and deaths can be prevented by simple immunization procedures, and that most neonatal deaths and maternal mortality probably can be stopped cold by proper health measures and hospital deliveries. For this

reason we must be certain to include all available preventive medical services in our rural hospital set-up.

HEALTH UNIT CONSTRUCTION

Some new concepts enter into the construction of such a health unit. In the first place it would be unwise to attempt to construct a unit with an estimated lifetime of more than twenty-five years. This is a radical departure from the present trend of hospital construction, but I believe it is a very necessary one, since we have good reason to believe that vast improvements in rural hospital facilities will take place within the next two decades, rendering obsolete the establishments which we are now considering. This means that construction of the unit may be greatly simplified, and that it will not be necessary to employ materials which are generally considered everlasting. In addition, it will not be necessary to incorporate into the details of construction many elaborate arrangements anticipating improvements which will occur in the equipment field twenty-five years hence. These are two factors in current hospital construction which have greatly increased the cost, and which can be greatly modified in the construction of a small country hospital.

Again, since these units are to be small, and presumably will be built in areas without satisfactory fire protection, it would be wise to plan all of the units on a one-story basis for protection of the patients in the event of fire, for necessary evacuation of the hospital, and for simplicity of construction. This will represent another saving in the over-all construction cost.

The country hospital unit must be arranged in such a manner that rapid transfer of patients from one area to another can be effected with very little strain on the staff, since there will be great variation in the hospital population as regards age and sex, and it will be necessary in many cases to provide immediate means of isolation. For this reason, it probably is better to have the hospital rooms built as private and semi-private units rather than to fall back on the old ward system which is found to be wasteful, even in large medical centers.

Finally, it must be emphasized that a very adequate laboratory set-up can be arranged at minimum cost; and it is probable that both laboratory and x-ray facilities can be easily managed by a single technician. In many cases, it will be necessary to have a well stocked pharmacy so that drugs can be dispensed, not only to patients in the hospital, but also to outpatients in those areas in which there is no nearby drug store to fill prescriptions.

PROPER LOCATION IMPORTANT

The location of this medical unit probably would be best chosen by a regional planning committee; but a word of warning I would pass on here is that strict adherence to the county line as a unit of population is likely to cause an unbelievable amount of difficulty in choosing the proper site.

In laying the groundwork for construction of these rural health centers, a regional survey is advisable; this can be best undertaken by compiling all available information with respect to density of population, prevalent medical needs, available medical services and general economic condition of the area. It is impossible to evolve a formula which will tell us the minimal density of population in a given radius which can support the medical unit but we may assume for rough purposes that the incidence of hospitalization among rural people in your state will be about one-third as common as is the case in urban populations. This figure probably will be revised upward as community confidence in the hospital grows and as the education of the population continues.

It is wise to attempt an estimate of the farthest distance a prospective patient is likely to travel to obtain medical care under ordinary circumstances. In my own mountainous community I have found that my people will travel from twelve to fourteen miles to seek medical assistance for ordinary conditions including obstetrical problems, acute medical illnesses and surgical emergencies. It is probable that in a relatively flat region with a good highway system, this radius of effective operation could be greatly increased and, accordingly, the size of the medical unit could be increased up to its maximum of 20 beds. These are factors which may be estimated, but will stand continuing revision, and hence may call for modifications of your rural hospital construction program from time to time in the light of past experience with the early prototypes which you will build.

It must be remembered that the extent of utilization of services provided will depend entirely on the degree of education of the population served by this unit, and by the attitude of the physicians who employ this workshop.

GRASS ROOTS MEDICAL FACILITIES

I believe that the most important factor in the success of these rural health centers is the extent to which the community or communities of the region will feel that the project is one of their own doing, and by the degree to which these people are able to contribute to the project in the

form of materials, labor and financial aid. If we plan to provide grass roots medical facilities, then these facilities must have their beginnings within the community or region which they are to serve, and must never be considered as a federal or state hand-me-down. This is a reversal of our present day trend to secure all possible help from sources at the head of our government, and finally to ask for a token contribution from the citizens who are most benefited by the construction of the hospital.

I do not wish to imply that these units should be constructed without any federal or state aid, for this would be practically impossible in the very areas which need them most; but I am certain that the more the community feels that it owns its health center, the more complete will be its continuing response to this medical facility.

If construction details can be worked out economically, and if arrangements can be made to utilize local materials contributed by citizens within the region, even to permit participation of free labor from the adjacent communities in the construction of the project, this would seem to represent a more natural approach to a rural situation. We have found this to be the case in my own community where a twelve-bed general hospital was built at a total cost of a little over a thousand dollars per bed as opposed to the prevailing cost estimates of about thirteen thousand dollars per bed elsewhere in the state.

Here in West Virginia you have a fairly large accumulation of unspent federal funds which have been made available to you under the Hill-Burton act. The primary intent of this act is to provide funds to assist with the hospital projects in rural areas. I urge you to utilize a fair portion of these funds for the construction of units such as we are describing; but do not make the mistake of failing to organize the rural communities so that they will extend themselves to the utmost in providing, maintaining and improving these facilities.

RURAL HEALTH CENTERS

Assuming that it will be possible to construct a number of rural health centers, let us consider some of the problems of maintenance which will be encountered. Very little information will be available to you on this score, because there are exceedingly few such units already in existence in rural America. Some new problems can be anticipated, however, with reasonable accuracy.

Because the actual construction expense of the rural health centers will be comparatively low, it must not be assumed that the operational cost of the institution will be below that of any other general hospital. The reasons for this are obvious. Because of the fact that the hospital unit is not designed for long term illnesses or for prolonged convalescent care, and will have very few available geriatric beds, it must be anticipated that the patient turnover will be at least twice as rapid as that in the larger general hospital. Furthermore, the volume of indigent admissions and outpatient care will be large because we are concerned primarily with a low income group of patients.

Unless a central pool for statewide purchasing and distribution of hospital items can be established for the entire chain of rural health centers, it will be necessary for each hospital to make its purchases in relatively small amounts, to be delivered by circuitous routes, and hence more costly than is the system of mass purchasing in a large metropolitan area.

In time, many of these financial problems can be greatly ameliorated by proper studies of tiny hospitals, but at the outset one may anticipate a patient day cost of about $11.00 on a year 'round basis. Assuming that the staff is adequately paid, and replacements of equipment are anticipated and maintained, this means that inevitably there will be an annual deficit in the average rural hospital of between three and five hundred dollars per bed. A portion of this deficit must be made up by the communities which are served by the hospital unit, in order to maintain the proper community-hospital relationship. But it is clear that additional provisions must be made from the outset to secure a fair amount of operational deficit funds from the county and a proportionate amount from the state and, finally, a token amount of matching money should be expected from federal sources.

COMMUNITY CONTROL

Let me emphasize again that so long as the community bears its rightful portion of the financial burden connected with the hospital, that community can rightfully insist that no unnecessary state or government interference will be tolerated in the operation of the unit. The management of the rural hospital should be entirely in the hands of a rotating board of trustees made up of trustworthy persons of all segments of the community which is served by the unit and, aside from general statewide regulations as regards the function of the hospital, it should not be necessary that any external government controls be applied to the unit.

STANDARDIZATION OF HOSPITAL INSURANCE

A great part of the perplexing situation of deficit financing of the rural hospital could be eli-

minated in advance by a realistic approach to the indigent hospital problem on the part of welfare authorities in each county and throughout the state, whereby contracts could be secured for the necessary hospital care of certified welfare cases at the anticipated patient-day cost of that hospital. Another extremely wise financing move would be to provide a plan of hospitalization insurance to be made available to the rural population, supplied by voluntary nonprofit insurance groups, which insurance could be utilized in any hospital within your state regardless of county line or residence of the individual holding the policy. If you could achieve some such standardization of hospitalization insurance, then it is reasonable to assume that protection could be sold to the rural population without too much difficulty. This would, to a large extent, eliminate the problem of the medically indigent patient who can neither pay his hospital bill nor be properly certified as an indigent case. The question of hospital insurance is adequately covered today by my friend Doctor Mulholland, and I will make no further mention of this aspect of the problem. Certainly within the group here today are enough members of your welfare agencies to begin a planning body for a statewide program of medical care for indigent groups. Solve these two problems adequately, and the remainder of your rural hospital deficit will be met with very little effort.

EDUCATING FOR MEDICAL CARE

Thus far, we have disposed rather sketchily of the problems of obtaining doctors for rural areas, organization and construction of tiny rural hospitals, and planning for their continuing maintenance and operation. If these questions have seemed difficult to answer, let us consider now the most basic of all problems connected with rural health facilities. This is the question of education, both of the population which is to receive the medical services and of the physicians who will render these services.

With respect to the education of the rural population, it would seem to be the task of the people here today to prepare their neighbors for the proper utilization of the medical services which they will eventually receive. This means that the rural people must learn that if they are to be provided with a doctor and medical services on a twenty-four hour basis, they must not expect the physician to spend the majority of his time in reaching the sick patient; rather, the patient must be brought to the doctor in almost every case. This is a lesson which country people find very difficult to learn, but they can be taught and, in the interest of improved medical services, this must be done without question.

The doctor himself would do well to be established in the community near the eventual location of the health unit for several months prior to the beginning of actual construction of this unit in order that he may acquire a thorough working knowledge of all environmental conditions of his patients, and that he may act as a spark plug for the entire community enterprise. This will be possible only in those areas in which a resident practitioner is already available, and occasionally in cases in which a doctor will move to a rural area in anticipation of the unit to be built. It is essential, however, that the first five or six such health centers be accomplished with full community cooperation, since the establishment of a good precedent in this field will make succeeding ventures easier as time goes on.

With the establishment of a four-year medical school in your state, it is reasonable to assume that the accent in the teaching departments will be on provision of fully qualified general practitioners who will respond to the call for country doctors to man the units which have been described.

ALLOCATION OF FUNDS

Although it is not within the province of this paper to discuss fund allocation, I might suggest the following division segments: (1) one-third for the completion of a four-year medical school with an associated teaching hospital, (2) one-third for expansion of existing medium to large-size hospitals, and for construction of additional hospitals from 50 to 100 beds, strategically located throughout the state and which may be used as receiving centers for referred patients from tiny rural units, and (3) one-third for the construction of the early prototype health center units as described.

INTERN TRAINING CURRICULUM

In the four-year medical schools, regular apprenticeships with residing physicians in rural areas should be an established part of the intern training curriculum. This would provide for improved education of general practitioners with respect to the rural problems which they will face and will offer some relief to the country doctor from his round of activities as well as an opportunity to impart instruction to the interne. Finally, it would be desirable to have as a part of a residency in general practice, a period of months in which the resident should act as *locum tenens* for country doctors in various locations throughout the state, enabling these

doctors to return to the medical center for graduate instruction from time to time. As a result of such a plan, the educational system of country doctors could become a well rounded and self-maintaining program providing a continuing source of trained physicians properly prepared for the job ahead.

DELAY UNNECESSARY

I do not feel that it is necessary to delay the planning and initiation in construction of rural health centers until such a time as the four-year medical school is completed and larger receiving hospitals are in operation. It may not be wise to build more than a half dozen of these centers in the next five or six years, but this many will surely prove their worth and could be staffed without much difficulty. The value of these units from the point of view of preventive medicine alone would demand their construction as soon as possible, and with the simple addition of hospital facilities, the completed institution will fulfill all of its possible functions at once.

It is almost certain that as medical facilities are slowly provided for the outlying rural areas, these communities will awaken to the necessity of improved communications, and the first steps to improve the entire rural environment will have been taken.

If the plans outlined here today seem to have been too greatly oversimplified, I must apologize for this. I assure you that I have run on a small scale the entire gamut of difficulties of isolated rural practice, hospital planning, eventual construction and satisfaction of completion of just such a unit. I remain convinced that it can be done, that it should be done, and that I will see it done in the state of West Virginia.

THE TIRED MOTHER

Every practitioner is familiar with the problem presented by the overworked businessman or the tired mother. Diagnosis is not difficult but codification of nomenclature is a problem not yet solved.

It is not only incorrect, but grossly unjust to be required to classify a tired mother into one of the six types of psychoneurosis—hysteria, psychasthenia, hypochondriasis, anxiety state, neurasthenia, reactive depression, or mixed. As a matter of fact, most of these mothers are not psychoneurotic at all, they are just tired. Nor is the overworked businessman psychoneurotic; he may be tired and irritable, but he has been stable in the past and after his vacation will be again.—Leonard L. Lovshin, M. D., in Ohio St. Med. J.

Alcoholism represents a human being who is escaping from intolerable stresses and strains.—J. F. in Ohio St. Med. J.

PROBLEMS OF RURAL MEDICAL CARE*†

By H. B. MULHOLLAND, M. D.
Charlottesville, Virginia

With the tendency of doctors to settle in cities, the question of medical care in rural areas has become serious and both farm groups and physicians are concerned about the situation. This maldistribution of physicians is one of the basic causes of the lack of medical care. If, by some fortuitous circumstance, the percentage of doctors in urban and rural areas could be more equitably adjusted, the question would be at least partially solved. There is, however, no reason to believe that such an occurrence might take place any time in the near future. The relative unfavorable economic situation of rural people and rural doctors seems to play the next important role. Poor living conditions, comparatively smaller incomes than in urban areas, poorer schools and bad roads, all are contributory. The lack of association with one's colleagues may also tend to keep the well prepared man away from the country.

Another, and perhaps a major deficiency, is the lack of adequate facilities to practice medicine in a modern fashion. The cost of establishing and maintaining facilities such as x-ray equipment and a laboratory is beyond the means of most physicians.

Some five years ago, the American Medical Association recognized the importance of rural medical care and initiated yearly conferences which have been attended by large groups of farm people, where discussions of the needs and plans for solution of rural problems have taken place. Farm groups and doctors have learned to know and to respect each other through these conferences, and they have realized also that both physicians and farm people need to be educated on the subject of what constitutes good medical care.

Construction of needed facilities has been stimulated through the Hill-Burton Act. No federal aid plan is more universally accepted and praised. Through this help, the building of health centers and hospitals is now under way in every state in the Union. Fortunately, this aid is surrounded by sensible safeguards, and facilities are being built only where they are actually needed. As a possible solution to the rural medical problem, many of us feel that from now on, emphasis should be laid on the construction of so-called medical service centers housing ten to twenty-five beds, mini-

*Presented before the Rural Health Conference sponsored by the public relations committee of the West Virginia State Medical Association and held at Jackson's Mill, May 18, 1950.
†From the Department of Internal Medicine, University Hospital, Charlottesville, Virginia, and the Committee on Rural Medical Service of the American Medical Association.

mal x-ray and laboratory facilities, and doctors' offices. In such a center, several doctors could practice together and efficiently and economically use expensive facilities. These centers should be much less expensive to maintain than hospitals which must necessarily have more costly equipment. Furthermore, these centers would serve to awaken community participation and responsibility which is of fundamental importance.

Some states have set up correlated hospital systems where there is an exchange of interns from the base hospitals to the smaller units, and in connection therewith, postgraduate education emanating from the larger hospital. These facilities are closely related to the problem of prepayment hospital and medical and surgical insurance, because beds must be available in order that country people may derive benefits from such types of insurance.

Studies are being made by Blue Shield and Blue Cross groups to stimulate the purchase of policies amongst rural people. I am sure that if tenant farmers were organized, they would have an insurance of some type; and should we not ask farm owners to help in the payment of fees for such voluntary health insurance for their employees just as is done in industry? There is a large untilled field of education in teaching farm people the benefits of health insurance.

Care of the indigent in rural areas must be provided as well as in urban centers, and some system must be worked out — perhaps through voluntary insurance — to handle these people efficiently. Medical schools must assume their full responsibility to the rural population and more emphasis should be put on environmental medicine with an effort made toward indoctrinating these young men and women in the problems of rural medical care. Perhaps experience with the rural doctor for a definite length of time during their medical school career would be advisable. Indeed, in several medical schools this is being tried out at the present time. Scholarships for those who intend to practice in the country will help, and many states are giving such loan funds to students who agree to practice in rural areas for a given number of years. Unless these young men have a good economic status and adequate facilities, they still will not stay in the country. We should not forget that nurses, public health personnel and dentists are, too, of importance in the over-all picture of rural medical care. Systems of hourly nursing have proved most satisfactory in helping rural people handle severely ill patients.

Throughout the United States there is an increasing interest in the establishment of Health Councils. This movement, both locally and statewide is perhaps the keystone to the solution of any medical care problem. The local health council having as members representatives of government, clubs, medical professions, dentists, public health officers and nurses, voluntary health organizations and individuals can study health problems, determine the greatest needs, serve as a forum for discussion of all health matters and initiate plans to solve these problems and meet the needs. Only through such an unselfish coordinated effort on the part of all those interested in health will the final solution be found.

OUR COUNTRY'S RURAL HEALTH

Rural people are vitally interested in matters of health. Education and the ease of transportation have shown the people of rural communities that they, too, can have the same social advancement as their city cousins. Today electricity, the telephone, and modern mechanical time-saving and labor-saving devices have been made available for use in the rural areas as well as in urban areas. Now much attention is being focused on improving the general health of rural people.

Farm organizations and school organizations have included health topics as a part of their study programs. Extension services have done much to educate the farmer on the value of sanitation and animal husbandry, while the economics clubs and home demonstration agents have been conducting intensive education programs among farm women on home sanitation, food sanitation and preparation, and family health.

These programs, however, can go only so far under lay direction. Ultimately the time arrives when they must depend upon the medical profession to advise them on sound health practices. Today they are looking to our profession for the help and expecting our fullest cooperation. Their confidence in the medical profession cannot be dulled through our lack of assistance; in fact, we should offer our services, and help in every way possible through participation and consultation in the development of constructive and worthwhile health programs that individuals in the rural communities can put into practice.—Frank G. Sink, M. D., in J. Indiana St. Med Assn.

ACTH AND CORTISONE

We will need to change many of our concepts of certain diseases if cortisone and adrenocorticotropin (ACTH) live up to the expectations of present clinical evidence. From the reports to date, there has been nothing so dramatic in medicine. Few if any remedies have done so much in a short time.

The compounds are being used in arthritis, gout, rheumatic fever, myasthenia gravis, depressive states, nephritis, psoriasis, pemphigus, lupus erythematosis, periarteritis nodosa, and other chronic diseases.

Thus far, the results in general have been good. Time will tell, however, as all new products must be digested clinically before the final analysis. At any rate, we hope for the best.—Illinois Medical Journal.

RURAL HEALTH CENTERS*

By N. H. DYER, M. D.
State Director of Health
Charleston, West Virginia

It is a well known fact that some of our people are not getting adequate medical care. Also, it is well known that some of our people are not getting adequate benefit from preventive medicine or public health services.

I am referring, of course, to the people who live in the rural areas of our state. That is the reason we are here today to discuss means of improving the situation.

We might say that the problem is to increase the number of physicians and nurses, hospital facilities and local health units, and to better distribute their services in areas suffering from these critical shortages.

As the years go by, curative medicine and preventive medicine have slowly closed the gap between them. This is important, for as preventive and curative medicine become better integrated, we can better provide a total health program for the people of West Virginia.

One evidence of this alliance is the increased life span. Since 1900, the life span has been increased by twenty years. Along with this advance, however, came another problem, the problem of the aging and the aged. We want to keep the old people with us as long as we can and make them comfortable. We may not be able to meet the challenge completely but at least we can try, and are trying.

In rural areas, one answer to the problems that I have just mentioned is the establishment of community health centers. The purpose of a health center in a rural area would be to provide facilities for the public health program, to provide basic diagnostic facilities, to provide clinical space for practicing physicians in the area, and to provide emergency beds. There are many different plans for health centers but the one just mentioned seems to come closest to meeting our needs.

The health center would be headquarters for the local health department. It would be the base of operations in maternal and child health, sanitation, health education, public health nursing, and all the other activities of the department.

The doctor of today gets his training in an institution which has all the equipment needed for practicing good up-to-date medicine. The reason why we lack professional personnel in the rural areas is that the facilities to which the young doctor is accustomed are not available.

To help eliminate this drawback, the health center would have diagnostic facilities available. I do not mean the kind of facilities found in large urban hospitals, but enough equipment to perform routine diagnostic tests, x-rays, and so on.

The health center also would contain office space where the practicing physician could see patients. This would give the practitioner suitable space for his consultation, and he would have the diagnostic facilities at hand. In some areas, the physicians might have their own offices and would use only the diagnostic, emergency and public health facilities. Thus, by means of such a center, various kinds of arrangements might be provided which would make the practice of medicine in the rural areas more attractive.

The health center could provide another kind of facility, bed space for the care of emergency maternity cases, accidents and other emergency cases.

One thing that I might point out here is the difference between urban and rural health centers. We have several health centers in urban areas in West Virginia. But they provide only the facilities needed for the public health program. In the city there is no need for such facilities to duplicate the other medical care and hospital facilities which are, more or less, capable of meeting the needs of the community. It is a different picture in the rural area, however; these facilities are not available and must be provided by some means.

We are working very hard to get all of our people under the coverage of local health services. Standards of today recommend that there be a local health unit for every 50,000 people. On this basis, we need 22 local units.

Help in the construction of health centers to house these local health departments, as well as the other facilities I mentioned, is now available from the federal government. During the past two years this aid has not been as effective as we would have liked. The Hospital Construction Act provided for help in building hospitals, health centers and other medical care facilities by contributing one dollar to every two dollars put up by the local community. The trouble with this was that communities in most need of help were least able to pay for the costs of construction and maintenance. And, in most instances, these were rural communities. Even the one-to-two offer could not be accepted.

*Presented before the Rural Health Conference sponsored by the public relations committee of the West Virginia State Medical Association and held at Jackson's Mill, May 18, 1950.

However, the House of Representatives recently passed an amendment (now pending in the Senate) to the hospital construction legislation in which the amount of federal financial participation has been considerably increased. If the amendment is passed by the Senate, and there are indications that it will be, then hospitals and health centers in West Virginia can be constructed with local funds amounting to 37.71 per cent, the federal funds providing the remaining 62.29 per cent on each project. Such a plan should give great impetus to the construction of facilities in our rural areas.

Under this plan, federal funds will be available year by year for two years. It will give West Virginia approximately $5,000,000 for hospital and health center construction in the various high priority communities.

Finally, I want to stress that the state and local public health authorities are aware of the problems involved in medical care and health services for our rural communities and will do everything possible toward their solution.

DIABETES AND PROTEINS

Insofar as diabetes is concerned, I am inclined to believe that a real therapeutic advance will come with a lowering of the animal fat portion of the diet and replacement of a portion of the animal protein of our present day diets with vegetable proteins, at the same time keeping the total diet with all of its required nutrients at a good maintenance level.

Manufacturers of insulin will tell you that the pancreas of animals fed on rich grasses has a greater yield than that of those which have subsisted on lean pastures; and I have been informed that extra feedings before slaughter increase the insulin yield of the pancreas up to 25 per cent. It is known the world over that the incidence of diabetes is low where food is scarce, and it is not a mere coincidence that this country, the best fed land in the world, has the highest incidence of diabetes, its sequelae, and also its complications.

What we see from day to day in our clinical work is that a high blood cholesterol is definitely lowered in most cases after two weeks in the hospital on a weighed and measured diet. Our hope is that hyperlipemia or hypercholesterolemia in most patients will be found to be a reversible process.

By this last statement, I do not mean that cholesterol of and by itself is the specific cause of the complicating lesions. What I do believe is that hyperlipemia and hypercholesterolemia are part of that process, and that they may serve as an index to what is going on, but this is not yet fully understood.—Joseph H. Barach, M. D., in J. Florida Med Assn.

An electronic device called the Communicator, which enables the blind and deaf to communicate with others, has been developed by a research engineer of the American Foundation for the Blind.—R. N.

TUBERCULOSIS ABSTRACTS*

SILENT PHASE OF CANCER OF THE LUNG

Cancer of the lung has a silent phase and is detectable. The air within the expanded lung provides a natural contrast medium for the detection of changes in density. Small tumors growing in the periphery will cast a direct shadow. Smaller tumors centrally located cause a subsegmental or segmental bronchial obstruction, which will cast a shadow of the corresponding atelectatic segment. An airless segment will cast a shadow many times the size of the shadow of the tumor itself; thus there is actual magnification of centrally placed lesions which represent the great majority of all pulmonary cancer. This is fortunate, as small tumors within the pulmonary hilus might otherwise escape detection because of the growing of normal bronchial and vascular shadows in this area.

The case-finding program in tuberculosis is already performing a double service as the incidental finding of silent cancer has shown. Patients with suspicious abnormal areas of density apparent in a survey film have been observed; on exploratory operation these densities sometimes prove to be cancer. Although the discovery of cancer in tuberculosis programs has not produced startling figures, the follow-up of all suspect cases has been incomplete.

Rates of cancer growth vary, but there are isolated instances in which abnormal shadows existed for several years and yet on surgical exploration the lesion was found to be apparently localized. Exploratory operations also have been known to reveal extensive metastases. This in no way mitigates the value of screening unless recent roentgenograms were normal.

If the survey roentgenogram represents the first and only roentgenogram the patient ever had taken, who will deny that, if the person had been having annual examinations previously, cancer in an operable stage probably could have been discovered. It is impossible to say how often patients should be screened in order to give reasonable protection from cancer of the lung. As further experience develops, this point can be determined. Fcr the present, selective screening on an annual basis would seem to be wise. The highest yield will be among men over 45 years of age.

Screening the whole population and spotting abnormal pulmonary densities is the first step. Prompt and adequate investigation of suspects is equally important. Additional information can be obtained by: positional, stereoscopic, tomographic roentgenologic studies, cytologic examination of sputum, bronchoscopy, and exploratory thoracotomy.

Negative sputum or negative bronchoscopic examination does not prove the nonexistence of cancer. If the abnormal roentgenologic density cannot be explained with reasonable certainty on any other basis, surgical exploration should be advised.

Silent Phase of Cancer of the Lung, Richard H. Overholt, M. D. and Ivan C. Schmidt, M. D., J. A. M. A., Nov. 19, 1949.

*Issued monthly by the National Tuberculosis Association and furnished through the courtesy of The West Virginia Tuberculosis and Health Association.

The President's Page

The population of West Virginia is essentially rural. Census statistics show that approximately 72 per cent of all people reside in rural areas. The total, of course, includes many of those who are employed in our coal mines. With these things in mind, it is most fitting and proper that an issue of the West Virginia Medical Journal be devoted to medical care in rural areas.

While I have not yet read the scientific papers that are appearing in this issue, I am familiar with what is being said, as I participated in the rural health conference at Jackson's Mill, May 18, 1950. This meeting constituted a milestone in the efforts of two groups, farm and medical, to find a solution to the problem of medical care in our rural communities.

The problem has not been solved, but there has been a good beginning. The need for another rural health conference at an early date is admitted by members of both groups. I feel that it is only through such interchange of ideas that we can find the way. There is the closest cooperation between the two groups, a most friendly feeling, and, above all, the desire on the part of all to do something that will result in the extension of adequate medical care to all parts of our state.

A vast improvement in the situation can be expected when we are in a position to supply more doctors for service in rural areas. About the only way this can be done at the present time is for us to furnish a complete medical education in this state to students who are interested in this professional field. I believe that the day is coming, and soon, when this can be done, for I have every confidence in the world in the ability of our legislators to provide ways and means for the building and maintenance in West Virginia of a four-year school of medicine and dentistry.

C. E. Watkins

President.

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RURAL HEALTH AND MEDICAL EDUCATION

We are presenting this month our first rural health number, which features four very interesting papers presented May 18, 1950, at the first state wide Rural Health Conference at Jackson's Mill sponsored by the Public Relations Committee of the West Virginia State Medical Association.

Copies of this issue of The Journal are being mailed to farm leaders over the state in the hope that the next conference which will be held a few months hence will draw even a larger participating audience than that which comfortably filled the auditorium at the first meeting at Jackson's Mill.

We believe that the papers which are being printed will be of interest to all persons who are even remotely concerned with rural health, particularly rural medical care. There are many problems that will have to be solved before it can be said that our rural areas are being provided with adequate medical care.

The most pressing problem that confronts us is the acute shortage of doctors. This situation is becoming more desperate particularly in view of the fact that several of the members of the profession will within the next two or three months be called to active service with our armed forces.

We still contend that the best way to solve this one problem is to provide complete medical and dental education in this state for students who desire to complete a course in either of these professional fields. We ask for continued study by rural groups, together with members of the two professions, of the advisability of creating and maintaining a four-year school of medicine and dentistry in this state. We believe that with the aid of all groups interested some definite action may be had at the 1951 session of the legislature.

Too long have we waited for something to be done about medical education. If we are to go forward, some definite action will have to be taken without further delay. We can and will succeed if those who are so vitally affected by the doctor shortage will cooperate with other interested professional and lay groups and work hand in hand with members of the legislature, elected and to be elected, who have pledged their full support to the building of such a school.

NORMAL BLOOD PRESSURE RANGE

Hypertension is a serious condition. Some students of the subject feel that it is one of the most common and important of all cardiovascular diseases. Obviously the diagnosis of hypertension should not be made without a careful study of the patient. The chief difficulty, of course, in arriving at a diagnosis lies in the question as to what constitutes a normal blood pressure.

Many clinicians regard a systolic pressure of 140 and a diastolic figure of 90 mm. of Hg as the upper limit of normality regardless of the age of the individual. On the other hand, some physicians believe that these accepted limits do not necessarily apply to older people. Physicians have often made the observation that many persons with a high blood pressure live to a ripe old age. Women in particular, for reasons not well understood, are able to carry a high blood pressure with seemingly less damage to the organism than are men.

Recently it was pointed out by Master, Dublin and Marks, (1) of New York City, that the levels which constitute abnormally high blood pressure at various ages have not ben accurately determined. They emphasize, as previously mentioned, that many people who have blood pressure values above the recognized normal have the usual expectancy of life. These authors feel that the level of the generally accepted figures

(1.) Master, Arthur M., Dublin, L. I. and Marks, H. H.: The Normal Blood Pressure Range and its Clinical Implications. J. A. M. A. 143: 1464-1470 (Aug. 26) 1950.

of systolic and diastolic blood pressures should be raised for individuals who are over 40 years of age, and that the range of normal blood pressures should be reconsidered.

Master and his colleagues obtained blood pressure reading on 15,706 individuals—of these 7,722 were men and 7,984 were women. The data were obtained from industrial plants in various sections of the country and included executives, clerical, and manual workers. Some negroes were included but the great majority were of the white race.

Space does not permit a listing of all their findings, but some figures are in order. The authors give the normal range of systolic blood pressure for boys 16 years of age from 105-135 mm. of Hg and for men between the ages of 60-64, 115-170 mm. of Hg; for women of corresponding ages 100-130 and 115-175 mm. of Hg respectively.

The lower limit of systolic hypertension for young men (16-18 years of age) is given at 145 mm. of Hg, and for men in the early thirties 155 mm. For women up to the age of 30, 140 mm. of Hg is considered the lower limit of systolic hypertension. After women reach the age of 60, there is no appreciable difference in blood pressure from that of men.

The figures for the diastolic blood pressure, which undoubtedly give a better index of the load the heart has to bear, are also of interest. The normal diastolic pressures for boys and girls of 16 years of age were virtually the same, namely, from 60-85 mm. of Hg. The change with age was found to be gradual. Men in the early forties were found to have a range of between 70-94 mm. of Hg and from the ages of 60-64, approximately 100 mm. Women in the early forties had a range from 65-92 mm. of Hg and in the early fifties from 70-100 mm. of Hg.

The lower limit of diastolic hypertension for young men from 16-18 years of age was given at 90 mm. of Hg. The pressure gradually increases with age and in the early fifties rises to 110 mm. of Hg. Women follow about the same pattern.

Doubtless these figures presented by Master and his colleagues will not be accepted by all physicians. The values given, however, are of interest—at least until it can be proved that they are no longer tenable. The relatively high figures given by the authors of the limits of both systolic and diastolic hypertension are heartening to the physician. It is comforting to him to be able to give his patients, in a measure at least, the benefit of the doubt as whether or not to classify them as hypertensives.

OUR GRASS ROOTS PRESS

The weekly county newspapers of this country reach a class of citizenry which is only moderately contacted by the metropolitan daily and the magazines. And the county weekly is doing a fine job. Often we see editorials at the county level which would grace a daily with circulation running into six figures. The county papers represent the fourth estate at the grass roots and their editorial philosophy is, by and large, orthodox and sane.

Typical of these editorials, and one of the best we have seen, is entitled "Political Philosophies." It appeared in a recent issue of the Floyd (Va.) Press, and exemplifies grass roots philosophy so well and is so succinctly put that we quote it entirely:

"Basically there are but two political philosophies. One sets the citizens above the state – that is what we have had in this country under our representative form of government. The other sets the state above the citizen and results in the oppression that has bedeviled the human race throughout the ages.

"Currently, socialism and communism represent the ultimate in the latter philosophy. That is why present-day planners who advocate greater and greater government domination over the individual avoid these names like the plague. They promote government ownership of industry, they endorse compulsory medical taxes, they tour the country at the taxpayers' expense in support of Federal power 'authorities' and constantly harp on the theme that the capabilities of private industry are inadequate.

"Their program from start to finish is socialism, and yet if it is so defined they cry 'libelous'.

"Regardless of the sensitivities of the disguised socialist, it is of the greatest importance to define his aims. If this country is to abandon the system of government upon which it was founded, let's do it deliberately, not by subterfuge.

"In an outstanding editorial, the American Druggist declares: 'Up to now no important politician has openly asked us to choose between democracy and socialism or some other kind of statism, but we are being urged to support candidates for Congress who favor political programs that definitely express much more faith in governmen control than in the individual character and ability of the average citizen. . . .

'If we have come to the conclusion that the individual problems of most people are too much for them, and that the only hope is in a benevolent government, then let us set up a super government . . . but let us do it with our eyes open. On the other hand, if we still believe that the only real security for any citizen is his individual freedom of opportunity, it is our conviction that the time has come to stand up and declare ourselves.' "

Thank you, Editor Hallman, especially for your apt term, "medical taxes."

FARM BUREAU SPEAKS

The West Virginia Farm Bureau, at its 31st annual convention at Jackson's Mill, August 28-30, 1950, adopted the following strongly worded resolution opposing compulsory health insurance, but favoring support for prepayment plans:

It is widely recognized that the number of doctors and nurses in the state is inadequate, and that sufficient hos-

pital and other health facilities are not available to adequately take care of rural health needs. A well-planned and a well-executed long-time program is necessary to remedy this situation.

We urge everyone to become acquainted with the services offered by voluntary pre-payment plans for hospital and medical care. In this connection we recommend that County Farm Bureaus support such pre-payment plans in their respective counties.

The proposed compulsory health insurance program advocated by certain government officials will not solve our health problems and would increase governmental control over the daily lives of all of us. On this basis we express opposition to such proposals.

In the last analysis the solution to our health problems must be met largely by community action and by taking advantage of help from outside sources such as is provided by the Hill-Burton Act.

In the foreward printed in connection with the reproduction of the resolutions in the October, 1950, West Virginia Farm News, it was recommended that the boards of directors of county farm bureaus study the resolutions adopted and do everything possible to assist the State Farm Bureau in carrying them out.

We quite agree with the Farm Bureau that it would be most desirable to extend hospital and medical-surgical plan benefits throughout the rural areas of West Virginia. The plans at the present time, for the most part, are used most extensively in urban areas, but it has been very difficult to gain for them sufficient support in rural areas to justify an all-out rural program.

We believe that the Farm Bureau, the West Virginia State Medical Association, the hospitals and the medical and hospital service plans should continue to make every effort to interest those living in rural areas in the extension of voluntary plans so that families residing on our thousands of farms may have the benefit of proper protection in the matter of payment for medical care and hospitalization.

MEDICAL SCHOOL

With the opening of the fall term, the University of Michigan will commemorate the one hundredth anniversary of the founding of its medical school. In October, 1850, 60 students enrolled for courses in the new school. A local newspaper commented that if the bright prospects continued, "none of our young men in pursuit of medical science will have to resort to other states to complete their education."

How meaningful that statement could be in West Virginia, now, 100 years later, if such a school were being opened by our university. In 1850, Michigan had been a state but 13 years. Its then known resources were limited to lumber. Its manufacturing output was scant and of a local nature; the population was barely 400,000. The state owed its identity partly to the decision of Virginia to relinquish claim to its as part of the Northwest Territory. But even as a new state it had the courage to establish a medical school that has developed into one of the greatest medical centers in the world.

West Virginia has been a state for more than 87 years. It abounds in natural resources and teems with industry. Its population approximates 2,000,000. It, too, was once part of Virginia but unlike Michigan, its sons who wish to pursue medical science still have to resort to other states to complete their education.

It is long past time that something be done about it. The personal desires and short sighted thinking of a few individuals must be set aside and definite practical steps taken. Our ambitious and capable young people who are qualified for work in medical science are entitled to obtain it in our own state. The have been cheated long enough.—The Charleston Gazette.

THE DOCTORS ADVERTISE

There is something new under the sun and it occurs in this issue of the Observer. The American Medical association and the Mercer County Medical society are advertising.

You will read their advertisements with a good deal of interest.

This radical departure is brought about by the threat of socialized medicine. If you want to know how socialized medicine might work, you might study the activities of the State Road Commission of West Virginia and think what would happen if the politicians got the same control of the medical world as they do of the state and federal roads.

We can recall the days when doctors and hospitals were most hostile toward newspapers. It was very difficult to get from a hospital anything but a short answer when asking about the condition of a patient or of information about an accident.

However, we might say that the Princeton hospitals have always been cooperative about giving news and we have no knowledge of their having refused to give legitimate information. Getting back to the advertising, we are happy to see the doctors take this step—it will no doubt be profitable to all concerned.—Princeton Observer.

In order to protect patients from emanations of radioactive substances used in treatment of cancer and other diseases, hospitals of the future may have to be one-story buildings with lead-lined rooms, say scientists who are investigating cancer and allied diseases at the Brookhaven National Laboratory in Upton, Long Island. —R. N.

GENERAL NEWS

DOCTOR GROUPS HEAR LECTURES ON TREATMENT OF ATOMIC CASUALTIES

Doctors from 16 southern West Virginia counties attended a meeting at the Daniel Boone Hotel, in Charleston, Sunday afternoon, October 15, sponsored by the committee on emergency medical service of the West Virginia State Medical Association. The object of the meeting was to discuss treatment of atomic casualties.

A similar meeting, held at Clarksburg, October 8, was attended by doctors from 17 northern and central West Virginia counties.

Dr. Joseph J. Lawless, director of student health services at West Virginia University, was guest speaker at the Charleston meeting. Dr. Lawless has had special training in the medical aspects of atomic warfare, and recently attended a course given at Western Reserve University, Cleveland, by the medical staff of Western Reserve and Case Institute. This course was sponsored by the federal government.

Doctor Lawless told members of the audience at Charleston and Clarksburg, that "an informed medical profession, in cooperation with an adequately prepared civil defense organization, can markedly reduce mortality and suffering among the survivors of an atomic bombing."

"Man tends to recover from a large dose of radioactivity," Doctor Lawless said. "Adequate medical care, especially blood transfusions, can improve the outlook for the injured tremendously.

"Injuries from atomic bombing are similar to other war injuries, but there are many more of them at one time.

"All resources will be heavily taxed. Only by adequate preparation beforehand can we hope to save many of the injured survivors."

Dr. Charles D. Thomas, of the department of physics, West Virginia University, discussed the physical basis of atomic weapons at the Clarksburg meeting, but all planes at Morgantown on October 15 were grounded on account of fog and he was unable to be present at the meeting in Charleston.

Doctor Thomas has taken a special course on the detection of radiation, given by the federal government at Oak Ridge, Tennessee.

Meetings similar to the two held in West Virginia are being scheduled in various parts of the United States, as the AMA Council on National Emergency Medical Service, headed by Dr. James C. Sargent, of Milwaukee, feels that it is important that all doctors know something about the treatment of atomic casualties. The introduction of atomic weapons makes it not only desirable but necessary that doctors the country over be prepared to care for casualties resulting from the use of such weapons.

Dr. Thomas G. Reed, chairman of the committee on emergency medical service of the West Virginia State Medical Association, served as moderator at the Charleston meeting and was introduced by Dr. T. Maxfield Barber, president of Kanawha Medical Society.

At the Clarksburg meeting, October 8, the moderator was Dr. L. Rush Lambert, of Fairmont, a member of the committee on emergency medical service, and he was presented by Dr. John F. McCuskey, president of the Harrison County Medical Society.

HOSPITALS FOR WEIRTON AND WEBSTER SPRINGS

Weirton is the first city in West Virginia in the top priority group to meet the minimum requirements for federal aid in hospital construction. According to Dr. N. H. Dyer, state director of health, a 134-bed general hospital to cost $3,000,000 is to be built in that city. Of the total amount needed, the federal government will contribute $1,853,475.14. The remainder of the amount needed will be raised by contributions and general revenue bonds issued by the city.

The state department of health has approved and forwarded to the USPHS preliminary plans for a 30-bed hospital at Webster Springs, another community in the AA priority group. The total cost will be a little over $360,000, of which amount the federal government will provide about $225,000.

The two applications represent $2,077,779.18 of the $2,787,048 allotted to West Virginia for the current fiscal year.

Recent legislation enacted by Congress resulted in a cut of about 50 per cent in appropriations for hospital construction during the fiscal year, 1951-52. West Virginia's allocation for that year will be approximately $3,385,000.

FELLOWSHIPS IN INDUSTRIAL HEALTH

Announcement has been made that the Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of fellowships which are being offered to qualified candidates who wish to pursue a graduate course of instruction which will qualify them for the practice of industrial midicine. Candidates who complete the course of study will be awarded the degree of doctor of industrial medicine.

The course of instruction consists of a two-year preliminary training, including one year of practical experience in industry. Stipends during the first two years vary from $2,000 to $3,000. The candidate will be compensated for his services in the third year by the industry in which he is completing his training.

Full information concerning the fellowships may be obtained by writing to the Industrial Institute of Medicine, College of Medicine, Cincinnati 19, Ohio.

NUTRITION MEETING AT ELKINS

A joint dinner meeting of the West Virginia State Nutrition Committee and the Barbour-Randolph-Tucker Medical Society will be held in Elkins, November 16. Guest speakers will include Dr. Norman Jolliffe, director of the bureau of nutrition, department of health, New York City, who will speak on the subject of "Some Practical Lessons Learned from Recent Nutrition Surveys in Newfoundland and New York."

RELOCATIONS

Dr. Cyril P. O'Boyle, of Williamson, is taking a refresher course in radiology at a hospital in Philadelphia. His address there is 7139 Germantown Avenue.

* * * *

Dr. Hubert T. Marshall, of Martinsburg, district health officer, has moved to St. Louis, Missouri, where he will serve as assistant area medical administrator for the UMW Welfare and Retirement Fund. His address is 34 N. Brentwood Boulevard, Clayton.

* * * *

Dr. Emil Gribovsky, of Huntington, who has been taking a postgraduate course in internal medicine at Cornell University, New York City, and clinical electrocardiography and clinical heart diseases at the Peter Bent Brigham Hospital and the Good Samaritan Hospital in Boston, has returned to Huntington, where he will resume practice. He has offices at 824 Fifth Avenue.

* * * *

Dr. Parker H. Lee, Jr., of Bluefield, has moved to Lynchburg, Virginia, where he will continue the practice of his specialty of ophthalmology. He has offices at 705 Church Street in that city.

ANNUAL MEETING OF HEART ASSOCIATION

As this issue of the Journal is on the press (October 27), the annual meeting of the Heart Association is being held at the Hotel Pritchard, in Huntington. New Officers and members of the board of directors will be elected at the meeting.

Dr. Irving S. Page, Director of the Research Division, Cleveland Clinic Foundation, is one of the guest speakers. His subject is "The Nature and Treatment of Hypertension." He will be followed on the program by Dr. Arthur J. Merrill, Assistant Professor of Medicine and Research Physiologist, Emory University, at Atlanta, Georgia, whose subject is "Salt and Water Metabolism and Edema of Myocardial Failure."

The West Virginia Heart Association is an affiliate of the American Heart Association. Dr. John E. Stone, of Huntington, is president. State headquarters are maintained at Charleston, with Mrs. Caroline R. Rainbolt in charge as executive secretary.

DR. JAMES L. WADE NAMED PARLIAMENTARIAN

Dr. James L. Wade, of Parkersburg, has been named parliamentarian to the House of Delegates of the West Virginia State Medical Association. The appointment, which is for the term ending December 31, 1950, was made by Dr. Charles E. Watkins, the president, under the provisions of a resolution offered by Dr. S. S. Hall, of Clarksburg, and unanimously adopted at the second session of the House of Delegates at White Sulphur Springs. July 23, 1950.

MLB SCHEDULES WINTER MEETING

The winter meeting of the Medical Licensing Board will be held in Charleston, January 8-10, 1951, for the purpose of examining applicants for license to practice medicine in West Virginia.

WEST VIRGINIA DOCTORS ON PROGRAM FOR SOUTHERN MEDICAL MEETING

A large delegation of West Virginia doctors will attend the 44th annual meeting of the Southern Medical Association at St. Louis November 13-16.

Dr. R. J. Wilkinson, of Huntington, first vice president of the Association, will head the delegation from West Virginia. Dr. Andrew E. Amick, of Lewisburg, a member of the council, will leave in time to attend the meeting which will be held in connection with the convention.

The usual high class scientific program has been arranged for the meeting, every section of the Association being represented on the program.

The address of the president, Dr. Hamilton W. McKay, of Charlotte, North Carolina, is scheduled for Tuesday morning, November 14. That evening the Southern Medical Association's research medal will be presented by the president to Dr. Guy L. Hunner of Baltimore "for clarifying the relationship of focal infections as disease producers in the genito-urinary tract, and especially for his constructive work in the diagnosis and treatment of the medical and surgical diseases of the urinary tract."

Dr. Curtice Rosser, of Dallas, Texas, will be installed as president at this session, and the past president's medal will be presented to Doctor McKay by Dr. W. L. Pressly, of Due West, South Carolina, chairman of the council.

Dr. N. H. Dyer, state director of health, of Charleston, will address the Section on Public Health on November 16. He will speak on the subject of "Cooperation Between Organized Medicine and Public Health."

Dr. Ralph S. McLaughlin, also of Charleston, will present a paper on November 16 before the Section on Ophthalmology and Otolaryngology. He will discuss "The Treatment of Chemical Eye Injuries," and his paper will be illustrated with lantern slides.

Dr. James R. Bloss, of Huntington, will open the discussion of the paper on "The Psychic Aspects of Sterility and Abortion," which will be presented November 16 by Dr. Thodore E. Mandy and Dr. Arthur J. Mandy, of Baltimore.

Dr. J. J. Brandabur, of Huntington, is vice chairman of the Section on Industrial Medicine and Surgery, and Dr. T. Kerr Laird, of Montgomery, is vice chairman of the Section on Surgery. Dr. Howard A. Swart, of Charleston, is vice chairman of the Section on Orthopedic and Traumatic Surgery.

Dr. A. P. Hudgins, of Charleston, will present a scientific exhibit on "Relief of Postoperative Perineal Pain."

TB AND HEALTH ASSOCIATION ELECTS

Mr. Paul Lowther, of Clarksburg, was elected president of the West Virginia Tuberculosis and Health Association, at the annual meeting held in Bluefield, September 20-21. Dr. Karl J. Myers, of Philippi, was named vice president, and Dr. H. H. Howell, of Madison, secretary. Mr. Robert C. Hawkins, of Charleston, was reelected treasurer.

PR CONFERENCE AT CLEVELAND

The third annual Medical Public Relations Conference, sponsored by the American Medical Association, will be held at Cleveland, Ohio, December 3-4, immediately preceding the clinical session of the AMA. The meeting will be attended by executive secretaries, public relations committee chairmen, and editors of State Medical Journals, who will be in Cleveland for the AMA interim session.

The conference will be opened with a luncheon on Sunday, December 3, with Dr. John W. Cline, of San Francisco, president-elect of the American Medical Association, as the guest speaker.

Reports of public relations work in county medical societies will be presented at the Monday morning session, and three discussion groups will sit Monday afternoon to consider public relations problems in small, medium, and large communities.

The new "TV Package Show," which is being produced by the AMA for use by county medical societies, will be demonstrated at the final session on Monday afternoon, December 4.

SOUTHERN MEDICAL AUXILIARY AT ST. LOUIS

The 26th annual meeting of the Woman's Auxiliary to the Southern Medical Association will be held conjointly with the Southern Medical Association convention at St. Louis, November 13-16, 1950, with Mrs. Robert C. Haynes, of Marshall, Missouri, presiding as president.

Mrs. V. Eugene Holcombe, of Charleston, is first vice president of the National Auxiliary. She is a past president of the Woman's Auxiliary to the American Medical Association. Mrs. U. G. McClure, of Charleston, is a member of the Council. Her term expires in 1952. It is expected that both Mrs. Holcombe and Mrs. McClure will attend the annual meeting, together with Mrs. John P. Helmick, of Fairmont, who was president in 1944-45.

ACCA ELECTS NEW OFFICERS

Mr. Robert J. Wilkinson, Jr., of Huntington, was elected president of the American College of Clinic Administrators at the first annual meeting held October 9, at the Greenbrier, at White Sulphur Springs. Mr. E. R. Denison, of Philippi, was named vice president, and Mr. Carl R. Parrish, of Richmond, secretary-treasurer.

The following doctors were elected to honorary membership in the College: Robert K. Buford, Charleston; Hu C. Myers, Philippi; R. J. Wilkinson, Huntington; Herbert Acuff, Knoxville, Tennessee; and Mr. John R. Mannix, Cleveland, Ohio.

The primary objective of the group is to raise the standards of clinics and scholarships in the field of clinic administration throughout the country.

DR. LEO M. SELTZER CERTIFIED

Dr. Leo M. Seltzer, of Charleston, has been certified as a Diplomate of the American Board of Obstetrics and Gynecology.

EXPANDED ROLE FOR A. M. A.

Most recent criticism from within the profession is regarding the AMA's action in fields other than those relating strictly to the advancement of medical science.

The AMA was reluctant to deviate from its primary objectives, but faced the challenge in a time of real crisis for the future of our profession—as any active, forward-looking professional organization should do. It saw the necessity for strong and far-sighted leadership when faced with the possibility of the imposition of a socialized program which would be a tragedy for the people we serve and the profession we love.

The AMA is composed of human beings—you and other physicians. Human beings sometimes err in judgment. If, in your judgment, this seems to be the case, get it off your chest by discussing it with your colleagues at the stated meetings of your Society.

The only medical organizations that can solve the many social, political and economic problems of medical care are the American Medical Association and its constituent state and county medical societies. These are the organizations in which most physicians hold memberships, and, therefore, are the only ones that can speak authoritatively for the medical profession on national, state and county levels. These organizations should be strengthened.—New York Medicine.

FEAR

Our colleague, just returned from England, tells us that the dominant note there is one of fear. English doctors are timid in expressing their opinions of the Health Service. Afraid of what may happen! Why did all significant opposition to "socialized medicine" in Britain collapse? Again it was fear.

The British Medical Association has carried on what was thought to be an intelligent and effective program of opposition but at the last moment the doctors would not stand up and be counted. There was fear of losing their income, of being penalized in one way or another, and as the physicians yielded individually the fighting front crumbled. The British Medical Association is often blamed but in the last analysis it was the individual doctor who was at fault.

The lesson is clear. We fear "socialized medicine"—both its effects upon the public and upon the science of medicine—but intelligent and concerted opposition must be based not on fear but on something more. We must proclaim our Bill of Rights, and be willing to sacrifice individually and collectively without fear of consequences if suitable standards of medical practice are to survive.—Westchester Medical Bulletin.

NO NEUTRAL GROUND

The 38th parallel in Korea has a counter-part on our home front.

It is a line that separates the idea of regimentation by the state and the American principle of freedom for the individual. It has been drawn boldly across important issues by those who insist upon centralized power as an integral part of social legislation. Socialized medicine has been made one of these issues.

In November American voters will meet along this line. There is no neutral ground.—Conn. St. Med. J.

"A high percentage of cases of seasickness and carsickness can be aborted or prevented by suitable doses of dimenhydrinate (Dramamine)."

—Council on Pharmacy and Chemistry, New and Nonofficial Remedies, J.A.M.A. *143*:815 (July 1) 1950.

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OBITUARIES

OWEN POLING, M. D.

Dr. Owen Poling, 66, of Eskdale, died September 26, 1950, in a Charleston hospital, following a long illness. Although he had retired from active practice in 1948, he had done relief work for doctors in his area during the summer of 1949.

Doctor Poling was born at Kentuck, in Jackson County, son of Jane (Rhodes) Poling and the late Benjamin Newton Poling. He attended public schools in his home community, and West Virginia Wesleyan College, at Buckhannon. He had his pre-medical training at Bennett Pre-Medical School, in Baltimore, and received his M. D. degree in 1916 from Loyola University, Chicago. He was licensed to practice in West Virginia in 1916, and practiced at Elkview and several other communities in the Kanawha Valley before locating at Eskdale.

He was a member of the Logan County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Besides his widow, he is survived by two sons, H. B. Poling, of Rupert, and Thurman Q. Poling, of Jacksonville, Florida; his mother, Mrs. Benjamin N. Poling, of Charleston; a brother, W. L. Poling, of Pt. Pleasant; and a sister, Mrs. C. J. Hicks, of Charleston.

COUNTY SOCIETIES

CABELL

Dr. L. B. Gang, of Huntington, was elected president of the Cabell County Medical Society at the regular monthly meeting, held October 12 in the new Science Hall, at Marshall College. Other officers were elected as follows: Vice president, Dr. E. J. Humphrey, Jr.; treasurer, Dr. Frank M. Booth, Jr. (reelected); secretary, Dr. James A. Heckman (reelected); and, board of censors, I. E. Taylor and C. G. Willis.

The new officers will serve during 1951.

The following delegates were elected for 1951-52: Drs. F. L. Coffey, N. F. Hines, C. A. Hoffman, Howard R. Crews, and M. L. White. Alternates were named as follows: Drs. R. M. Wylie, Chauncey B. Wright, W. B. MacCracken, R. J. Stevens, and L. F. Dobbs.

The following doctors were elected to membership in the Society: William Kessler Marple, Florence Kunst Hoback, Melville Homer Cummings, Jr., and Harvey Stanley Klein.—James A. Heckman, M. D., Secretary.

* * * *

FORT HENRY ACADEMY

The fourth season of monthly scientific programs of the Fort Henry Academy of Medicine was inaugurated September 26, with a meeting in the auditorium of the Wheeling Hospital Nurses Home, in Wheeling.

The guest speaker was Dr. Walter G. Maddock, Alcock professor of surgery at Northwestern University Medical School, Chicago, who discussed "New Concepts of Pre & Post Operative Care," "Electrolyte Balance," and "Observations on Gastro-Intestinal Distention."

The discussion was opened by Dr. Edward S. Phillips and Dr. William J. Steger, both of Wheeling.—Robert U. Drinkard, M. D., Secretary.

* * * *

KANAWHA

Dr. David Scherf, associate professor of medicine at the New York Medical College, New York City, was the guest speaker at the regular monthly meeting of the Kanawha Medical Society, held October 10, 1950, at the Daniel Boone Hotel, in Charleston.

The speaker was head of the first heart station of the University of Vienna from 1930 to 1938. He has written numerous books and articles on cardiology and electrocardiography. He has been in the medical news lately because of his conception of the cause of auricular flutter and fibrillation.

Dr. Scherf presented a very interesting paper on "Pulmonary Embolism." He led a roundtable discussion of the subject at the conclusion of his address.—Robert C. Bock, Secretary.

McDOWELL

Mr. Thomas A. Deveny, executive secretary of the West Virginia Tuberculosis and Health Association, was the guest speaker at the regular monthly meeting of the McDowell County Medical Society, held October 11, at Welch. The speaker presented an interesting paper on the organization and work of the Association throughout West Virginia.—Otis E. Linkous, Jr., M. D., Secretary.

* * * *

MERCER

Dr. Eben Alexander, associate professor of surgery at Bowman Gray School of Medicine, was the guest speaker at the regular monthly meeting of the Mercer County Medical Society, held September 18, 1950, at Pete's Grill, in Bluefield. His subject was "Cerebral Aneurisms."

The Society voted unanimously to have inserted in all of the newspapers published in Mercer county publicity condemning socialized medicine. This program will augment the October advertising campaign of the American Medical Association.

Dr. William Mark Bruch, of Bluefield, and Dr. J. R. Parsons, of Princeton, were elected members of the Society.—Frank J. Holroyd, M. D., Secretary.

Cook County Graduate School of Medicine

Announces Continuous Courses

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting November 27, January 22.
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting November 6, February 5.
Surgical Anatomy & Clinical Surgery, Two Weeks, starting November 20, February 19.
Surgery of Colon & Rectum, One Week, starting November 27.
Gall-Bladder Surgery, Ten Hours, starting April 23.

GYNECOLOGY—Intensive Course, Two Weeks, starting February 19.
Vaginal Approach to Pelvic Surgery, One Week, starting March 5.

OBSTETRICS—Intensive Course, Two Weeks, starting March 5.

RADIATION PHYSICS—Intensive Review Course, Four Days, starting November 29.

ROENTGENOLOGY—Diagnostic & Lecture Course First Monday of every month.
Clinical Course Third Monday of every month.
X-Ray Therapy every two weeks.

DERMATOLOGY—Informal Clinical Course every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

PEDIATRICS—Informal Clinical Course every two weeks.

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MINGO

The first fall dinner meeting of the Mingo County Medical Society was held September 13 in the ballroom of the Mountaineer Hotel, in Williamson.

The guest speaker was Dr. Reno B. Porter, assistant professor of internal medicine at the Medical College of Virginia, Richmond. His subject was "The Diagnosis and Treatment of Coronary Heart Disease."

In his discussion, the speaker presented a new concept of the etiology of coronary occlusion, i. e., that most cases were due to arteriosclerosis which, in turn, were due to a defect in a certain fraction of cholesterol as shown by ultra-centrifugation technique.

Doctor Porter reviewed the highlights of diagnosis and treatment of angina pectoris and coronary occlusion. He stated that sections of infarcted heart muscle could be excised experimentally.

Dr. E. T. Drake presented a 13 year old boy with a congenital heart defect. The case was diagnosed by Doctor Porter as a Lutenbacher syndrome, which, he stated, is not amenable to surgery at the present time.

At the business meeting preceding the scientific program, Mr. Gaujot Bias, an attorney of Williamson, asked that individual members join the Chamber of Commerce. He stated that the Chamber had done much to win the fight against socialized medicine and that he felt that doctors should lend full support to its activities in the Williamson area.—E. T. Drake, M. D., Secretary.

* * * *

OHIO

At the regular meeting of the Ohio County Medical Society, held October 10, at Wheeling, the following Wheeling doctors were elected to membership: William E. McNamara, Jr., Howard L. Seabright, and George R. Mullins, the latter by transfer from the Logan County Medical Society.

Dr. Robert M. Sonneborn was elected vice president of the Society to succeed Dr. John H. Murphy, who is in Philadelphia taking extensive postgraduate work. —R. Alan Fawcett, M. D., Secretary.

GOOD PUBLIC RELATIONS

Good public relations consists not only of doing good but telling the world about it. The present day interest in public health education provides us with an opportunity to let the people know what we are doing in the great variety of health, welfare, medical care and allied fields of human programs.—Fred Sternagel, M. D., in Polk County (Iowa) Medical Bulletin.

SENSITIVITY TO ALLERGENS

Although sensitivity to allergens is, of course, the immediate cause of allergic rhinitis and allergic sinusitis, the sensitivity itself may be but a symptom of a chemical imbalance arising from dietary deficiencies. —J. F. in Ohio St. Med. J.

WOMAN'S AUXILIARY

HARRISON

The first fall meeting of the Woman's Auxiliary to the Harrison County Medical Society was held September 14, at the Clarksburg Country Club. Mrs. Ross P. Daniel, of Beckley, president of the State Auxiliary, was the honor guest. In addition to members of the local Auxiliary, Mrs. Daniel, Mrs. John F. McCuskey, Clarksburg, state president elect, and Mrs. L. D. Zinn, first vice president, also of Clarksburg, were in the receiving line.

The tea which followed the business meeting was under the direction of the social committee, of which Mrs. Zinn is chairman.

Mrs. Richard K. Hanifan, president of the Harrison Auxiliary, presided at the meeting which was attended by 36 members and two guests.

The regular monthly dinner meeting of the Harrison County Auxiliary was held October 5, at the Waldo Hotel, in Clarksburg, with Mrs. R. K. Hanifan presiding as chairman. This was a tri-county meeting, with members from the Marion and Monongalia Auxiliaries being present, together with representatives from Doddridge and Preston counties.

The honor guest was Mrs. V. Eugene Holcombe, past national president of the Woman's Auxiliary to the American Medical Association, and now first vice president of the Southern Medical Auxiliary.

Mr. J. T. Van Voorhis, of Clarksburg, was the guest speaker. His subject was, "Good Government is Our Business."

Reports concerning the Auxiliary convention at White Sulphur Springs last July were presented by Mrs. George F. Evans and Mrs. Sobisca S. Hall.

The meeting was attended by 44 members and 14 guests, and a social hour was enjoyed by all present following the scientific and business programs.—Mrs. E. Burl Randolph, Secretary.

* * * *

KANAWHA

Dr. Roy Bird Cook, of Charleston, was the guest speaker at the joint luncheon meeting of the executive board of the Woman's Auxiliary to the West Virginia State Medical Association and the Kanawha Auxiliary, held October 3, at the Daniel Boone Hotel, in Charleston.

Doctor Cook held the interest of all present by a vivid and detailed description of early medical practice in West Virginia. He discussed many interesting events in the lives of the early practitioners in the Kanawha Valley, particularly the part played by the wives of the doctors.

Mrs. Ross P. Daniel, president of the State Auxiliary, was the guest of honor and spoke briefly when she was presented at the luncheon. Dr. William A. Thorn-

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hill, a member of the advisory board, was also a guest at the luncheon.

Mrs. P. A. Tuckwiller, the president, presided and the invocation was given by Mrs. U. G. McClure. Arrangements were in charge of Mrs. John W. Hash, who was assisted by Mesdames T. Maxfield Barber, Jack Basman, Preston Champe, Vincent T. Churchman, M. L. Bonar, U. G. McClure, T. H. Blake, H. W. Angell, and Carl Tully. Mrs. J. Preston Lilly arranged the unusual floral display on the tables.

The luncheon meeting was attended by over a hundred members of Kanawha Auxiliary and officers of the state executive board.—Mrs. John C. Condry, Secretary.

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MARION

Mrs. Ross P. Daniel, of Beckley, president of the State Auxiliary, was the guest speaker at a luncheon meeting of the Woman's Auxiliary to the Marion County Medical Society, held September 26, at the Field Club, in Fairmont.

Mrs. Daniel spoke most interestingly concerning the National convention at San Francisco, the state and national organizations, and matters concerning the work of the Auxiliary, including specifically the duties of members.

A full report of the state meeting at White Sulphur Springs, in July, was presented by Mrs. Seigle W. Parks.

Mrs. George T. Evans, the new president of the Marion Auxiliary, presided at the luncheon, and other state officers present were as follows: Mrs. John F. McCuskey, Clarksburg, president elect; Mrs. Lynwood D. Zinn, Clarksburg, first vice president; and Mrs. Seigle W. Parks, Fairmont, recording secretary.—Mrs. George H. Traugh, Corresponding Secretary.

* * * *

MERCER

Mrs. Eva Counts, of Princeton, who is in charge of the Mercer County TB Clinic, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Mercer County Medical Society, held October 2, at Pete's Grill, in Bluefield.

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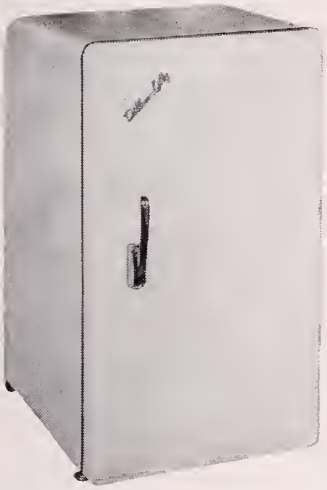

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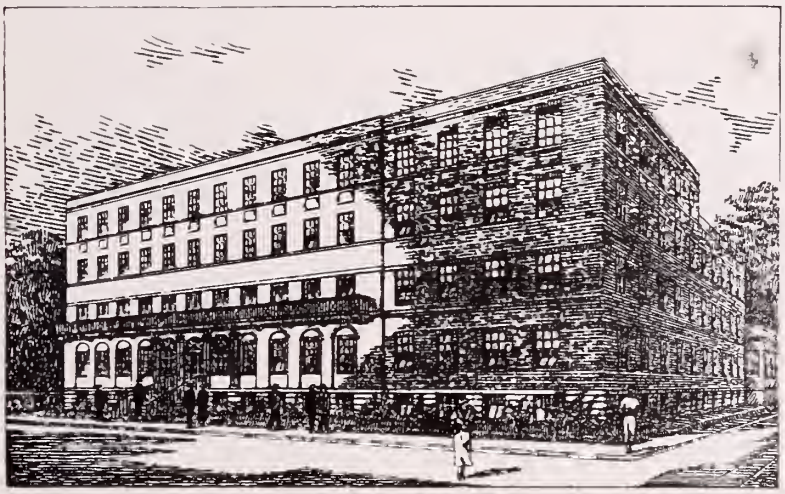

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The speaker presented an interesting and informative paper on the work that is being done in Mercer county, explaining the organization, setup, and the various duties of the voluntary workers.

It was reported that the Auxiliary is purchasing an x-ray film dryer for its year's project, which is the work of the local TB and Health Association. The dryer is already in use.

The Auxiliary voted unanimously to send Christmas gifts to all Mercer county patients in sanitoriums in West Virginia.

Mrs. Bowling, of Princeton, entertained with several musical selections at the piano. The tables for the luncheon were decorated with fall flowers, marigolds and trailing ivy being featured.

Mrs. Robert Gatherum, of Bluefield, presided at the meeting in the absence of the president, Mrs. Frank J. Holroyd.—Mrs. D. V. Kechele, Secretary.

* * * *

MINGO

A report of the annual meeting of the Auxiliary at White Sulphur Springs was presented by Mrs. E. T. Drake at the regular monthly luncheon meeting of the Mingo County Auxiliary, held October 12, at the Mountaineer Hotel, in Williamson. Mrs. Drake, who is chairman of the program committee, also submitted details concerning the program for 1950-51.

Reports were also given concerning the activities of the Auxiliary during the past year, including participation in the "Crusade for Freedom" project, and the TB Mobile Clinic project in Mingo county.

The Auxiliary will place "Today's Health" in the public library and various schools in the county. Mrs. Russell A. Salton is chairman of this project.

Mrs. J. C. Lawson, the president, has named the following committee chairmen for the ensuing year: Membership, Mrs. J. E. Johnson; Parliamentarian, Mrs. Ella Lawson; The Bulletin, Mrs. W. W. Scott; Today's Health, Mrs. R. A. Salton, Jr.; Legislation, Mrs. Will Price; Public Relations, Mrs. Walter S. Feldman; Program, Mrs. E. T. Drake; Necrology, Mrs. F. Robert Lawson; and Publicity, Mrs. Henry C. Hays.—Mrs. H. C. Hays, Publicity Chairman.

* * * *

OHIO

The Woman's Auxiliary to the Ohio County Medical Society held its first meeting of the fall September 12, at the home of Mrs. C. J. Holley, in Wheeling. The meeting was in the nature of a tea and reception for new members. Hostesses were Mesdames Francis J. Gaydosh, D. E. Greeneltch, W. Carroll Boggs, and Warren D. Leslie.

The members of the Ohio County Auxiliary were guests of the Belmont County (Ohio) Auxiliary at a luncheon held September 21, at the Belmont Hills Country Club, in Martins Ferry.

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Mr. Henry Mazer, conductor of the Wheeling Symphony orchestra, was the guest speaker at a luncheon meeting of the Ohio County Auxiliary, held October 17, at the Wheeling Country Club. Hostesses for the occasion were Mesdames Carl S. Bickel, George R. Clarke, and R. U. Drinkard, Jr., all of Wheeling.

A fall "doctor's day", sponsored by the Ohio County Auxiliary, was held October 21 at the summer camp of Mr. and Mrs. George E. Strobel, on Big Wheeling creek. Each member of the Auxiliary was invited to bring her husband to the meeting, where various forms of entertainment including dancing, bridge, and Canasto were enjoyed.

Mrs. W. E. Ackerman, Jr., served as chairman of the committee on arrangements, and the other members were Mesdames W. Carroll Moggs, Francis J. Gaydosh, Robert T. Bandi, and Chesterfield J. Holley. —Mrs. W. E. Ackerman, Jr., Corresponding Secretary.

* * * *

RALEIGH AND FAYETTE

Mrs. Ross P. Daniel, of Beckley, president of the Woman's Auxiliary to the West Virginia State Medical Association, was the honored guest and speaker at a joint luncheon meeting of the Auxiliary to the Raleigh and Fayette Medical Societies, held September 20, at the Black Knight Country, Club, in Beckley.

The speaker discussed the need for support of national and state medical and auxiliary publications. She also discussed in detail the program of the Auxiliary to the American Medical Association.

Mrs. R. G. Broaddus, of Beckley, president of the Raleigh Auxiliary, presided at the meeting, which was attended by 44 members and guests. Each member was presented with a copy of the new year book which was prepared by Mrs. W. C. Mays.—Mrs. G. F. Fordham, Corresponding Secretary.

* * * *

TAYLOR

The September meeting of the Woman's Auxiliary to the Taylor County Medical Society was held September 28 at the home of Mrs. Paul P. Warden, in Grafton, with Mrs. John F. McCuskey, of Clarksburg, president elect of the Woman's Auxiliary to the West Virginia State Medical Association, as the guest speaker.

Mrs. McCuskey discussed the objects and purposes of the organization of local auxiliaries.—Mrs. R. D. Stout, Secretary.

PLAIN SPEAKING

There was a railroad wreck and there seemed to be only one witness that actually saw what happened. He was asked to take the witness stand in court and the attorney roared at him and said, "You claimed that you saw the two trains collide head on at 60 miles an hour. Now tell us, what did you say when that happened?" And the witness answered, after shrugging his shoulders, "I just sez to myself, 'Now ain't that a hell of a way to run a railroad!' "—Detroit Medical News.

PHYSICIANS of the South have an urgent call to St. Louis for the annual meeting of the **Southern Medical Association**, Monday, Tuesday, Wednesday and Thursday, November 13-16. Medical meetings are essential in times of war as well as in times of peace. In the light of the world situation today this meeting of the Southern Medical Association may be the last complete general medical meeting to be held for some time to come. With this thought in mind, it is very important that all physicians take advantage of this opportunity to bring themselves up to date on the latest developments in the profession.

THE ST. LOUIS meeting will be one of the most complete medical meetings ever offered to the profession. Every phase of medicine and surgery will be covered in the general clinical sessions, the twenty-one sections, the five conjoint meetings and the scientific and technical exhibits.

REGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there will be at St. Louis a program to challenge that interest and make it worthwhile for him to attend.

MEMBERS of state and county medical societies may attend. Eligible physicians, members of state and county medical societies in the South can be and should be members of the Southern Medical Association. The annual dues of $8.00 include the Southern Medical Journal, a journal valuable to physicians of the South, one that each should have on his reading table.

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BOOK REVIEWS

CURRENT THERAPY 1950: Lotest Approved Methods of Treotment for the Procticing Physicion—Edited by Howord F. Conn, M. D. Pp. 736. Philodelphio ond London: W. B. Sounders Compony. 1950. Price $10.00.

This is the second annual edition of a work well received in 1949. Fifteen sections are presented, each dealing with diseases of an organ-system. There are over 250 well-known contributors.

Only therapeutic measures are considered; diagnosis is presumed to have been established. Each article presents the details of the treatment in use by an individual contributor for one specific disease state. Where there is variance among authorities, two or more types of treatment may be outlined, with no preference expressed.

The editors appear to be making a conscientious effort to keep the annual revisions truly current, so the work should be valuable to the busy practitioner.—Clark K. Sleeth, M. D.

* * * *

AN ATLAS OF HUMAN ANATOMY—By Borry J. Anson, Ph. D., Professor of Anotomy, Northwestern University Medicol School, Chicogo. Pp. 518. Philodelohio ond London: W. B. Sounders Compony. 1950. Price $11.50.

This is one of the most recent contributions to this field. The general scope of the work is excellent. Regions are adequately covered and supplementary plates used to portray more specific features.

The majority of the half tone plates show a good sense of depth, but many of the numerous line drawings fail in this quality. Furthermore several figures cover such small areas that their interpretation would probably offer difficulties to the beginner.

One excellent feature is the inclusion of many plates designed to show the range of variability in the vascular pattern, position of visceral organs, and other general relationships.

An objectionable feature of the entire work, especially to the beginning student, is the use of old terminology. For example gall bladder is *vesica fellea*.—Simon B. Chandler, M. D.

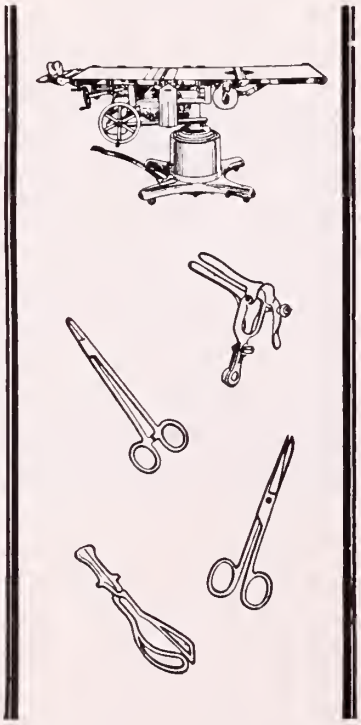
* * * *

FROM THE HILLS: An Autobiogrophy of o Pediotrician—By John Zohorsky, M. D., Steelville, Mo. Pp. 388. The C. V. Mosby Compony, St. Louis, Mo. 1949. Price $4.00.

"From The Hills" is an autobiography of a physician, written by the physician himself, John Zahorsky, of Steelville, Missouri, a highly civilized man, humorous, compassionate, humble and wise.

Writing easily and intimately, the author carries you through 387 pages of humor, pathos and determination, displaying common humility and dual roles of family physician, specialist, teacher, writer, and christian.

In this interesting and well written book, the author elaborates upon clinical cases and observations resulting



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from his own private practice. It is a book that will prove to be interesting not only to pediatricians, but to physicians engaged in general practice or the practice of some other specialty.—Andrew E. Amick, M. D.

* * * *

MEDICAL DIAGNOSIS: Applied Physical Diagnosis—Edited by Roscoe L Pullen, M. D., Professor of Graduate Medicine and Vice Dean of Tulane University of Louisiana School of Medicine, New Orleans. Second Edition. Pp. 1119, with 601 figures, 48 in color. Philadelphia and London: W. B. Saunders Company. 1950. Price $12.50.

The second edition retains the method of presentation by anatomic regions employed in the first edition. New sections on bedside diagnosis of blood diseases, medical diagnosis in the aged, and physical examination of the psychiatric patient have been added. In addition, three other sections appear to have been completely rewritten.

The chief value of this volume lies in the fact that it presents in compact form the diagnostic evidence which may be gleaned from clinical, laboratory, radiologic and other specialized techniques, including histologic. Illustrations are profuse and valuable, with considerable use of color. The book is well indexed. —Clark K. Sleeth, M. D.

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955 Fourth Ave.
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Business Manager
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VOL. XLVI DECEMBER, 1950 No. 12

THE ALARM REACTION:

Its Relation to Origin and Antihistamine Therapy of the Common Cold*

By JOHN M. BREWSTER, Captain (MC), USN†

In the spring of 1946 while taking one of the early varieties of an antihistamine for the treatment for urticaria, the abortion of a beginning cold was first experienced and subsequently reported.[1] Because this agent had been found extraordinarily effective for the treatment of various manifestations of allergy, and because the early symptoms of the common cold so closely resemble those of hay fever, it was assumed that the common cold began as an allergic reaction. Since then much time and energy have been devoted to the search for an adequate explanation of this phenomenon. More recently, I have become aware of the work of Hans Selye[2] and his theories concerning an alarm reaction, the general adaptation syndrome and the diseases of adaptation. Although he has not mentioned the common cold *per se* in any of his papers that I have read, from my understanding of his theories I feel strongly that the explanation of many of the mysteries of the common cold lies concealed in the pathologic physiology displayed by the body in its efforts at defense.

In 1946, in a comprehensive review of the subject, Selye defined the alarm reaction as "the sum of all nonspecific systemic phenomena elicited by sudden exposure to stimuli to which the organism is quantitatively or qualitatively not adapted". He further states: "It is becoming increasingly more obvious that certain physiologic mechanisms, in which the endocrine system plays a prominent part, help to raise resistance to damage as such, irrespective of the specific damaging agents. Some of the most important diseases of human pathology (such as hypertension, nephrosclerosis and the rheumatic diseases) may represent by-products of the endocrine reaction, which are at play in the general adaptation syndrome."

In his detailed discussions of the syndrome Selye cites symptoms and signs that are extreme and unmistakable. For example, in shock, which is described as the primary phase of the alarm reaction, he lists tachycardia, decrease in muscular tone and body temperatures, formation of gastric and intestinal ulcers, hemoconcentration, anuria, edema formation, decrease in blood chlorides, acidosis, a transitory rise followed by a decrease in blood sugar, leukopenia followed by leukocytosis and discharge of adrenalin from the adrenal medulla. He states, "This phase may last anywhere from a few minutes to twenty-four hours, depending on the intensity of the damage inflicted, but unless the termination is fatal it is always followed by the counter-shock phase. The latter is characterized by a reversal of most signs characteristic of the shock phase. Thus there is blood dilution and increase in blood volume, increase in blood sugar, and blood chlorides, alkalosis, diuresis, and often a rise in body temperature." After discussion of the stages of resistance and exhaustion he states, "These observations . . . led to the conception that any nonspecific noxious agent which causes sudden general systemic damage elicits the shock phase of the alarm reaction, probably because it liber-

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†The opinions expressed are those of the author and are not to be construed as official or reflecting the views of the Navy Department or the naval service at large.

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ates toxic metabolites from the tissues. The theory was proposed that if the damage is not too severe and hence permits survival, the damaging agent (perhaps through a hypothetical toxic metabolite produced under its influence) acts on the anterior lobe of the pituitary and stimulates it to discharge adrenotropic hormone. This in turn stimulates the adrenal cortex to produce an excess of corticoid hormones which help to raise the resistance of the body and elicit the characteristic counter-shock phenomena. . . . This defensive endocrine response is valuable inasmuch as it facilitates adaptation to stress (e.g., infections, intoxications, nervous commotions, cold, et cetera) but the resulting endogenous hormone overdosage may become the cause of certain cardiovascular, renal and joint diseases. Thus developed the concept that many of the most common maladies of man are diseases of adaptation, that is to say, the by-products of abnormal adaptive reactions to stress." Since the foregoing was published in 1946 a great volume of experimental work has been conducted using pituitary adrenal corticotropic hormone (ACTH), and the literature has been filled with reports of the astonishingly good results obtained.[3]

Because of an attack of coronary occlusion suffered last September, no experimental work has been done during this past winter and, in consequence, much of my present conception concerning the common cold is speculation based upon my previous work, the reports of others and more recent personal experiences. The questions in my mind are: Do not the early symptoms and signs of the common cold represent manifestations of an alarm reaction to weaker stimuli? Is not susceptibility to colds a manifestation of a disease of adaptation?

As emphasized by Selye, shock is the most common manifestation of the alarm reaction following heavy doses of alarming stimuli. Increased capillary permeability is an outstanding feature of shock. Again, as expressed by Halpern[4] one of the prominent properties of antihistamines is the ability to restore normal capillary permeability and combat acute edema. Several investigators, as noted in Selye's review[5, 6] have expressed the opinion that histamine liberation from the tissues may be the basic cause of the alarm reaction syndrome, irrespective of the exciting stimulus. Histamine and exposure to cold both have been widely used experimentally to produce shock and the alarm reaction in laboratory animals.

Williams[7] concluded, "I have suggested that physical allergy is a perversion of a normal physiologic reaction, the alarm reaction of Selye." In 1945, Troescher-Elam and associates[8] demonstrated that the nasal secretions in an acute head cold contained appreciable quantities of histamine. The phenomenal restults obtained by Bordley[9] and others in the treatment of allergies with ACTH, and the fact that allergy plays such an important role in rendering patients susceptible to colds,[10] is strong presumptive evidence that the early phases of the common cold are a manifestation of the alarm reaction. The fact that the antihistamines are effective to a lesser degree in controlling the symptoms of allergies lend further emphasis.

If we accept the alarm reaction as being the origin of the common cold, the divergent opinions of such eminent authorities as Andrewes[17] who believes that the common cold is caused by a virus and is contagious, and those of Kerr[18] who believes that it is an "affliction" and not contagious, are immediately reconciled. Both can be true under certain circumstances.

A diagram has been drawn to graphically illustrate a conception of the progressive steps in the development of the common cold, the role that the alarm reaction plays in its origin and the stage in development where the antihistamines accomplish their good results in treatment. It also serves to suggest where ACTH or possibly one of the adrenal hormones might accomplish even better results.

Assuming for the sale of argument that my conception is approximately correct, what are the alarming stimuli that touch off the common cold? These include toxins from the growth of viruses or bacteria, pollens, molds, smokes, irritant gases, exposure to cold (especially during periods of low barometric pressure and high humidity), emotional stresses such as grief, worry, excessive sexual activity, and excessive muscular fatigue and dietary indiscretions including the ingestion of food and drinks to which one is allergic, as has been demonstrated by many investigators[19, 20, 21, 22, 23, 24, 25, 26, 27].

All of us recognize that the quality and degree of resistance to disease and stress vary widely between individuals composing any large group, depending upon the pathology already existing in those individuals, upon their diet, their vitamin intake, their emotional adjustment and the degree of normality of their physiologic processes, especially those governed by the endocrines. Thus at one extreme, we have the completely normal individual who never contracts a cold; at the other are those who seem never to be without a cold in some stage of its course. Most of us are in between these extremes and we contract colds only because our resistance is temporarily lowered, giving rise to what I believe can be considered the alarm reaction and the consequent liberation of histamine or a histamine-like sub-

stance. This freely circulating histamine-like substance causes a failure of the thermoregulating mechanism with the production of more alarm stimuli and the initiation of the rspiratory system response with one or more of the following symptoms: sneezing, nasal blocking, rhinorrhea, lacrimation, chilly sensations, dry cough, headache and malaise. If antihistamine therapy is started

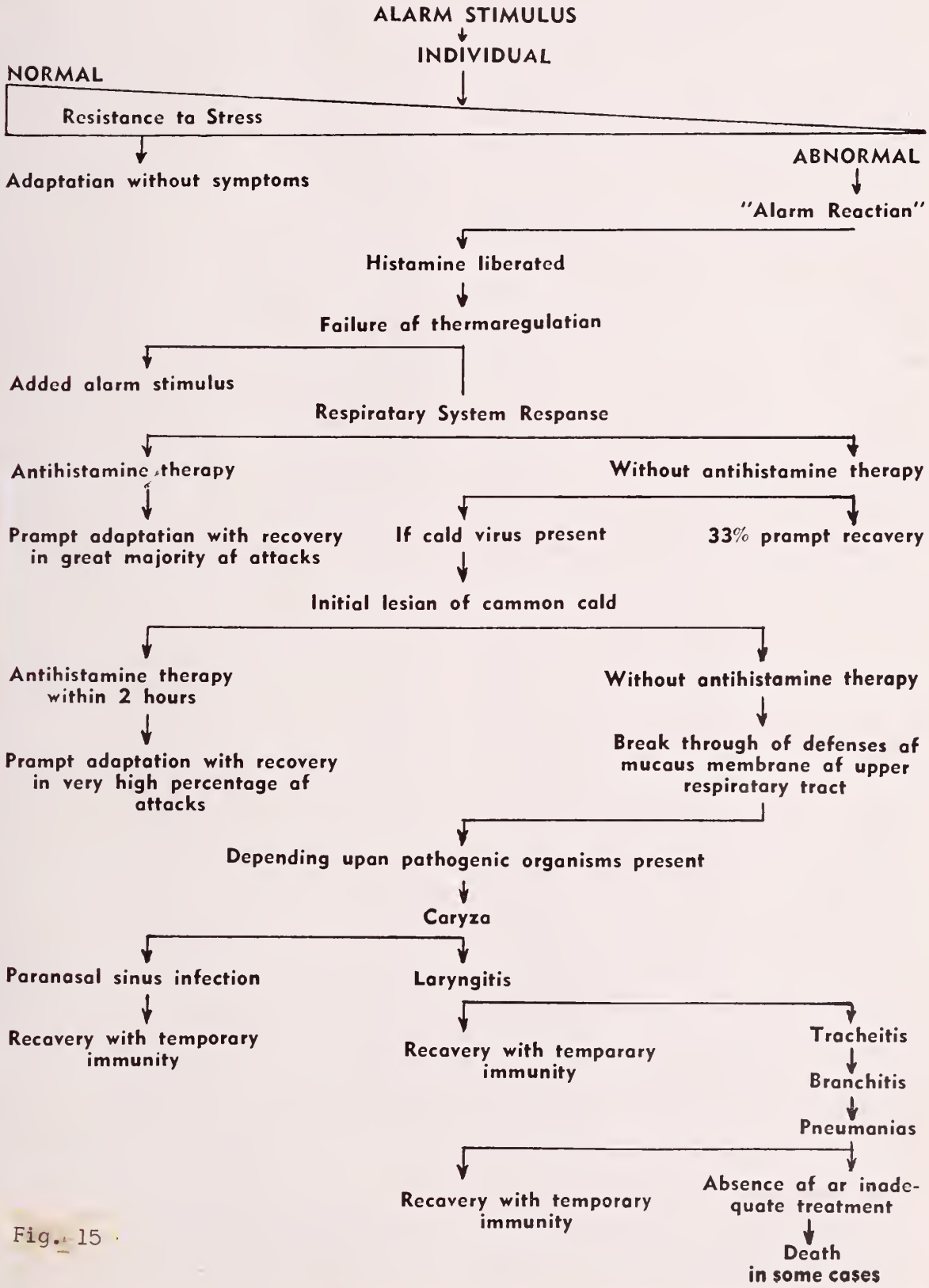

Fig. 15

promptly at this point, recovery occurs in the great majority of cases;[26] without this therapy, about one-third of a given number of persons will recover spontaneously.[27] If the cold virus is present, the primary lesion of the common cold will develop, which lesion is believed to be sharply localized in the mucous membrane of the upper respiratory tract, detectable to the patient as a point of soreness. It is possibly directly analagous to the lesion of herpes simplex or fever blister in the skin. In the light of the findings of Kline and his co-workers[28] concerning the histologic changes in allergic wheals· it is postulated that both might be considered the clinical equivalents of the Arthus phenomenon as it has been produced in laboratory animals. Also it may be the equivalent of the ulcers occurring in the gastrointestinal tracts of animals during the alarm reaction. Like the herpes lesion, it may develop suddenly and with intensity or, in contrast, depending upon the strength of stimulus, so insidiously that the victim cannot state definitely when he first became aware of its existence. It is well known that in the lesion of herpes, there is a destruction of superficial cells at its center which results in an open sore, scab formation and, finally, healing after many days. In my own person I have been able to completely abort these lesions whenever a therapeutic dose of an antihistamine has been taken promptly as soon as the lesion was detected.[1] When treatment has been delayed beyond an hour (and it must be remembered that when an antihistamine is taken by mouth almost an hour elapses before it becomes effective), it has been found that tissue destruction already had taken place and although the antihistamine did control the edema and relieve the itching, the scab formed just as it always had under any other type of treatment.

This is essentially the case in the common cold. If antihistamine therapy in effective dosage is started within an hour after the appearance of the primary lesion, recovery is prompt in a very high percentage of attacks. In the absence of antihistamine or other effective therapy, the defenses of the respiratory mucous membrane are breached. The resulting illness and complications depend in large measure upon the pathogenic organism present on the surface of that mucous membrane and able to take advantage of the opportunity thus afforded to invade the body.[16]

From this, it becomes apparent that many attacks of colds can be aborted as long as they remain uncomplicated allergic type alarm reactions. The privilege of aborting a cold is reserved for those who have learned to detect the initial lesion, those who are willing to begin treatment of it promptly and those who have been provided with the medication in advance of the attack. For this reason, it is virtually impossible to abort colds in children.

From experience to date, it is now believed that the antihistamines are preferred treatment within the first hour or two of the common cold only, and that thereafter symptomatic relief alone can be effected. This would seem to be a proper place for me to confess that with few exceptions, I have always started treatment of my own colds with antihistamines within an hour of the appearance of symptoms and have obtained uniformly excellent results in aborting most attacks. This has made me prejudiced and more than willing in previous papers to interpret as cures the favorable reports of my patients who had begun the treatment at much longer intervals after the onset of symptoms. These reports were therefore probably erroneous in so far as they dealt with cures when treatment was begun more than an hour or so after onset of symptoms.

The following is admittedly a poor analogy, but compare the initial allergic type response of this manifestation of the alarm reaction with the situation produced by physical injury such as that of an arm caught in machinery when the protective envelope of the skin is breached. In the latter we know from experience that many common pathogenic organisms will grow in the seed bed thus produced if we fail to act to prevent them. We know that each passing moment is precious; we know that it is an emergency and we treat it as such· with commensurate rewards. Let us in like manner recognize that this initial physiopathologic response in the mucous membrane of the upper respiratory tract creates an equally fertile seed bed from which a wide variety of diseases spring. Let us consider it too as a minor emergency and give it an equally energetic and rational prophylactic treatment. Not for a disease entity, but for this exaggerated and often inappropriate response. I believe that we should accept it as a diagnosis in itself and treat it promptly with therapeutically effective doses of one of the antihistamines which are specific for many of its manifestations.

Recently, it has been proposed that the Navy undertake experiments using ACTH in efforts to abort attacks of the common cold, not with the idea of advocating its use in treatment but as a means of dissolving some of the mystery that now envelops the condition. It is my hope that I may share in this work if it is undertaken. I am quite confident that it can be demonstrated that it arises from the alarm reaction and that marked susceptibility to colds is a disease of

adaptation as these terms have been defined by Selye. The recent suggestion of Sackler[30] that histamine might be an "antidyne hormone" is very stimulating and should excite further investigation.

As now produced and used, ACTH, by stimulating other endocrines in addition to the many functions of the adrenals, resembles a charge of buckshot that produces unpleasant consequences as well as miraculously good results in a wide variety of diseases. It is reasonable to hope that eventually the individual pellets of this charge may be isolated and the appropriate ones used in treatment of this manifestation of the alarm reaction.

Several papers have appeared recently[31, 32] which reported negative results from the use of antihistamines in the preventation and treatment of colds. The qualifications of their authors are beyond question and their findings therefore must take precedence over those reported by me. However, I question that they contain the whole truth. Some of these observers are among those who earlier demonstrated that neither vitamins nor vaccines were effective in the prevention or treatment of colds. There are still some of us who believe that both are important as preventive measures, not in the case of everyone, but in the cases of those in the subnormal group which harbors those who suffer most of the colds and nearly all of the very severe attacks. The fact that none of the treated patients in Feller's series experienced any symptomatic relief would seem to betray a prejudice against the antihistamines that rivals my own in favor of these agents.

Finally I will quote from Dr. Victor C. Vaughan, one of the earliest investigators in the field of reaction of animal tissues to abnormal stimuli, who wrote, in 1893, as related by W. T. Vaughan:[33] "The value of a theory does not wholly depend upon its truth, but is rather to be measured by the fruitfulness of the lines of investigation that it opens. Indeed, a theory may be wholly erroneous and yet it may lead to most important discoveries."

If those of you who have not already read Selye's comprehensive review published in the February 1946 number of the Journal of Clinical Endorcrinology have been stimulated to do so, then I shall be consoled that I haven't wasted your time. It has already revolutionized our thinking and conception of many diseases and much pathology. It's importance can scarcely be overestimated.

CONCLUSIONS

1. There is evidence that the common cold has its origin in a modified manifestation of the alarm reaction of Selye.

2. The antihistamines are effective in overcoming this reaction when it is moderate and when they are used promptly within an hour of its onset.

DISCUSSION

Question: (Dr. Barber) Which antihistamine do you prefer?

Answer: The one that accomplishes the desired result without too much side-effect. It has been my experience that the ability of these agents to block histamine is almost in direct proportion to the degree of sedative effect produced by them. In general, my experience coincides with that of Sternberg and his associates as reported in the J.A.M.A. recently. He found benadryl to be the most effective, with pyribenzamine, neoantergan and hydrillin close behind it and about on par with one another. Other varieties are both somewhat less effective and have fewer side actions.

Question: (Dr. Kessel) What is your regimen of treatment?

Answer: It is my policy to let my patients try a dose of one or more of the antihistamines when they are well so that we both can learn the effects. Having found one that is acceptable, each patient is provided with a small quantity to be kept at hand at all times. They are instructed to take a full therapeutic dose at the first definite sign of a cold, to rest, if possible, and to repeat the dose at 3½ hours intervals for two more doses, then return to me for further instructions and additional medicine. It has been my experience that if the effects of the first dose are allowed to wear off before the second becomes effective the cold will never be aborted. The increased capillary permeability and the edema must be overcome and the effect maintained for at least ten hours to be consistently effective. I usually give an effective dose of aspirin with the first dose to insure prompt symptomatic relief, and repeat it with all doses given at bedtime.

If a cold is not aborted the antihistamines are given in smaller doses just often enough to control sneezing and rhinorrhea and to obtain rest. They are combined with other standard drugs and nose drops when required to obtain the desired effects. They are never given in the presence of a fever which is considered to be evidence of infection by a secondary invader requiring an antibiotic or a sulfa drug for control in most cases.

ADDENDUM

Since the above paper on "The Alarm Reaction" was written, additional papers (18) covering this subject have been published. A review of

all of them suggests the following factors to explain the poor results reported:

(1) Neither small doses of potent antihistamines nor large doses of weaker antihistamines are any more effective in the treatment of colds than in any recognized form of allergy.

(2) Aside from and complicating the picture of true virus colds there are two divisions in the group of diseases and conditions covered by the diagnosis "Common Cold" in most such studies which govern the statistics reported:

(a) "Traumatic," "allergic" or pseudo colds which occur in all months and climates but predominate in the spring and fall and respond well to antihistamines.

(b) Infectious colds which include misdiagnosed cases of many other virus diseases such as the influenzas as well as some due to streptococci. The predominate in the dead of winter, are refractory and require early adequate doses of potent antihistamines and a sustained effect while the initial lesion is still reversible.

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TREATMENT OF ALCOHOLISM WITH ANTABUSE

(Tetraethylthiuramdisulfide)*

By V. E. MACE, M. D.,**
Charleston, West Virginia

Antabuse is the Danish trade name for tetraethylthiuramdisulfide which is frequently referred to as TETD. Patients who have taken this drug have an abnormal reaction to alcohol. This reaction to alcohol in patients prepared for treatment with antabuse is believed to be due to the increase of acetaldehyde in the blood, this substance being formed by some unknown reaction of the drug on the enzymes oxidizing alcohol in the organism. Acetaldehyde is regarded as a normal intermediate product in carbohydrate matabolism.[1] All the effects of alcohol, after antabuse is taken, can be duplicated by continuous intravenous infusion of acetaldehyde. The severity and duration of the reaction are directly proportionate to the amount of antabuse and alcohol in the body and to the disposition of the individual.[2] Hypersensitivity of a patient to alcohol begins three to four hours after the ingestion of a single dose of antabuse and is fully developed during the next twenty-four hours.[1]

Since August 24, 1949, we have treated thirteen cases of alcoholism with antabuse at the Mace Memorial Nursing Home. These patients were all white men between the ages of twenty-seven and fifty-nine, the average age being forty-four years. Each patient had been gradually sobered and had taken nothing containing alcohol for forty-eight hours before starting the treatment. Psychotherapy and an attempt to make domestic and economic adjustments were used to bring about mental and social rehabilitation. Thiamine hydrochloride, multiple vitamins, insulin, glucose and liver extract were used to restore physical rehabililtation.

Our antabuse routine is as follows: Grains 5 three times a day after meals the first day, grains 5 twice a day after meals the second day, grains 5 after breakfast the third to the seventh day inclusive, and gains 1 to 3 after breakfast each day following. Tests are given on the fourth and seventh days, and usually on the thirtieth day. The patient is permitted to go home on the eighth day, but returns for the thirtieth day test. From our observations and laboratory work antabuse is a comparatively safe drug if the patient is in reasonably good health and is free of alcohol. The blood concentration of alcohol probably can go up to 400 mg. per hundred cubic centimeters, which would be quite dangerous, but the antabuse reaction would prevent the concentration from reaching such a level in a previously sensitized patient.

Bell and Smith,[2] in a series of nine cases, reported what we would consider severe reactions in two cases in which 0.5 Gm. of antabuse had been given daily for a period of four days in the absence of alcohol. The venous blood concentration of alcohol at the height of symptoms was 25 mg. per hundred cubic centimeters, but the amount of alcohol given was not mentioned; presumably, it was that quantity of alcohol contained in 1½ to 3 ounces of whiskey. Of three other patients given 1½ to 3 ounces of whiskey, one showed a blood concentration of 39 mg. per hundred cubic centimeters. The symptoms in all five cases were almost identical. Another patient in this series, who weighed 185 pounds, was given 2 ounces of whiskey initially and 1½ ounces at thirty-minute intervals for two more doses, making a total of 5 ounces over a period of one hour. In eleven minutes his breathing ceased (temporarily), but was reestablished through the use of artificial respiration and oxygen. At this time the measured venous blood concentration of alcohol was 62 mg. per hundred cubic centimeters. From these findings one could conclude that 1 ounce of whiskey will give a blood alcohol concentration of about 10 to 12 mg. per hundred cubic centimeters. It would appear also, from these observations, that not more than four 1½ ounce doses of whiskey should be given at thirty-minute intervals during a test. These findings concide with those in our experience; however, our daily dosage of antabuse at the time of a test is 5 grains instead of 0.5 Gm. According to Bell and Smith,[2] if beer is to be used, eight ounces is equivalent to one ounce of whiskey. This obviously is not 3.2 per cent West Virginia beer.

The antabuse tests are conducted by giving the patient 1 or 1½ ounces of whiskey at thirty-minute intervals. The initial dose of whiskey is estimated by the size of the patient and by his previous capacity for alcohol. The intervals between doses are somewhat determined by the severity of the reaction to each preceding dose. This severity helps also to determine the size of the succeeding doses for that particular test, and it primarily determines the patient's daily dosage of antabuse after he leaves our institution. Only 100 proof bonded whiskey was used in our tests, one ounce of which is equivalent to 10 Gm. of alcohol.[2]

In ten to thirty minutes after whiskey is given, the patient's face begins to flush and he perspires freely. The sclerae become definitely inflamed,

*Presented before the Raleigh County Medical Society, at Beckley, West Virginia, June 15, 1950.
**Medical Director, Mace Memorial Nursing Home.

the upper half of the body becomes very erythematous and usually the lower half is flushed. The patient becomes extremely nervous, and in two of our cases there were crying spells. Another patient was seized with hysterical laughter, and two others talked incessantly during the tests. There appears to be a slight initial rise in blood pressure which later falls markedly. This fall in blood pressure, when the patient is made to stand up, causes unsteadiness, dizziness, pallor, weak thready pulse and apparent impending collapse, but these symptoms soon disappear when he is permitted to lie down. The patients often experience a metallic or a garlic-like taste, nausea and, in a few cases, vomiting. The vomiting, however, is not constant, and was severe in only two of our cases. In some cases the pulse rose to 140 and the respiration to 34. The temperature range was between 97 F. and 99.6 F.

Practically all thirteen of our patients complained of headache, throbbing through the temples, and palpitation, and three complained of dyspnea. Angina-like constriction and burning in the chest were looked for carefully, but were observed in only three cases, and in these the symptoms were very mild. Marked cyanosis was noted in two cases. Practically every case passed large quantities of urine of low specific gravity, but careful urinalysis showed no other changes. Two patients complained of vague pains in the back and lower extremities and, oddly enough, these were the only patients to note anything unusual after antabuse was started and before the tests were begun. Both of these patients complained of a feeling of pressure on their foreheads which, however, was slight and fleeting. All patients became sleepy (and usually were sleeping) in from one-half to two hours after the tests were completed.

Psychotherapy was used to install fear of the possible danger if alcohol were taken on the outside after sensitization to antabuse. Such therapy is an important adjunct in any treatment of alcoholism, especially antabuse treatment.

Our results are not glowing achievements in the treatment of chronic alcoholism, but they do offer much hope. Our follow-up of these thirteen cases shows the following: Nine of our patients have not touched alcohol since their antabuse treatment; two broke over for one short period each; one broke over for two short periods; one case (our first) was a complete failure.

Our first case embraces a period of eight months, and our last case four months. These results show that approximately 69 per cent of these patients have totally abstained, 15 per cent were greatly improved, 8 per cent were moderately improved, and 8 per cent received no benefit from the treatment. If only 40 or 50 per cent of these cases remain permanently arrested, great will be the reward. The series is small and the time short, but the results are encouraging. Since antabuse is a comparatively safe drug, it merits further investigation.

Alcholics Anonymous probably has done much for the apparently hopeless drunkard. It is to be hoped that antabuse treatment plus psychotherapy will do much more. The antabuse system of treatment neither deprives a patient of his self-pride nor forces him to admit that he is a failure. A combination of these two systems might prove to be the salvation of coming generations from alcoholism.

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USE OF GASTROSCOPE IN DIAGNOSIS

Although the use of the gastroscope in this country is only now about seventeen years old, it has earned for itself a very significant place in the diagnosis of diseases. It might well be emphasized at this point that the gastroscope is not a competitive diagnostic procedure, but is an adjunct to the usual diagnostic procedures now in common use; that is, the taking of an adequate history, adequate physical examination, gastric analysis and radiographic examination of the stomach. As a matter of fact, radiographic examination of the stomach is urged before gastroscopy to assure the endoscopist of no complicating lesions in the esophagus before attempting a gastroscopic examination.

Gastroscopy has found its greatest field of usefulness in the differential diagnosis of gastric disease rather than as a primary diagnostic feature. It is very frequently helpful in the diagnosis of upper gastro-intestinal bleeding of obscure origin in which other diagnostic procedures have not been helpful and in those cases in which the radiologist is unable to define a lesion or is unable to determine whether a lesion found is malignant or benign. It is always indicated in an individual who presents upper gastro-intestinal symptoms in which other diagnostic studies have failed to demonstrate the cause of the complaints.—Aubrey B. Harwell, M. D., in Acuff Clinic Bulletin.

DIAGNOSIS OF ESOPHAGEAL LESIONS

Any part of the esophagus can now be approached with confidence by the well trained thoracic surgeon. Consequently, the exact diagnosis of esophageal lesions has assumed more importance than it held formerly, when no therapy other than palliative treatment was available. Any patient with complaints referable to the esophagus is entitled to such diagnostic procedures as are necessary to establish a postitive diagnosis. It is only by strict adherence to this principle that cancer of the esophagus can be treated early enough to avoid a fatal outcome.—W. Ralph Deaton, Jr., M. D., and H. H. Bradshaw, M. D., in North Carolina Medical Journal.

CANCER OF THE STOMACH

A Review of Cases Treated at the Myers Clinic Hospital from July 26, 1933 to May 1, 1950

By JOHN E. SUMMERS, M. D.
Philippi, West Virginia
(Now Chief Surgeon U. M. W. of A. Union Hospital, West Frankfort, Illinois)

NUMBER OF CASES

From July 26, 1933 to May 1, 1950, a total of 55 in-patients have been treated for cancer of the stomach at the Myers Clinic Hospital.

SEX INCIDENCE

Forty patients (75%) were males; 15 (25%) were females.

NUMBER OF CASES TREATED PER YEAR

Year	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
No. Cases	1	1	1	0	0	3	5	1	5	1	4	3	4	8	8	6	2	2

CHIEF COMPLAINTS

The chief complaints in order of frequency:

Complaint	Number of Patients with Complaint
Pain in stomach	26
Epigastric distress	16
Vomiting	11
Nausea	6
Weakness	4
Dyspnea	2
Loss of weight	2
Pain in chest	2
Swelling of stomach	1
Paresthesia	1

SECONDARY COMPLAINTS

Complaint	Number of Patients with Complaint
Gas	16
Constipation	13
Loss of appetite	13
Sour stomach	9
Weakness	8
Swelling of ankles	5
Nausea	4
Loss of weight	3
Nervousness	3
Tarry or bloody stools	3
Jaundice	1
Vomiting	1
Vomiting of dark blood	1

AGE DISTRIBUTION

Age in years	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85
No. patients	1	4	0	7	14	11	6	7	3	2

DURATION OF SYMPTOMS

Duration of symptoms when patient was first seen:

Months	1	2	3	4	5	6	7	8	9	10	11	12	13-18	19-24	Over 2 yrs.
No. of Patients	2	5	7	5	2	8	1	3	1	2	0	3	7	1	5

Duration of Symptoms in Relation to Operability

Duration of symptoms in operable cases (subtotal gastrectomy).

Months	1	2	3	4	5	6	7	8	9	10	11	12
No. of patients	1	2	3	2	1	3	0	1	1	1	0	3

One patient had had "stomach trouble" for 30 years.

DURATION OF SYMPTOMS IN INOPERABLE CASES

(No operation or palliative operation).

Months	1	2	3	4	5	6	7	8	9	10	11	12	13-18	24	36
No. of patients	1	1	3	3	1	5	1	2	0	1	0	0	7	1	3

WEIGHT LOSS

(One patient gained 11 lbs. dues to ascites).

Lbs. Lost	6	8	10	12	14	16	18	20	22	24	26	28	30	Over 30 lbs.
No. of patients	2	2	0	2	5	1	4	3	0	3	4	0	4	12

PHYSICAL EXAMINATION

The main abnormalities noted on physical examination:

Abnormality	Number of Patients
Emaciation	46
Epigastric mass	23
Epigastric fullness	4
Enlarged liver	5
Ascites	4

RELATIONSHIP OF A PALPABLE EPIGASTRIC MASS TO RESECTABILITY

A definite epigastric mass was felt in 23 patients. Fifteen of these patients had an exploratory laparotomy performed. In only two patients was subtotal gastrectomy attempted. One died postoperatively. The other patient had subtotal gastrectomy performed on 4-27-45, and he is alive and well at the present time.

BLOOD COUNT

The R.B.C. taken on admission is given; some of these patients were dehydrated at this time.

R.B.C. in Millions	2	2½	3	3½	4	4½	5 to 6
No. of patients	3	2	6	5	17	5	11

GASTRIC ANALYSIS

Gastric analyses were performed upon 24 patients. In two of these analyses bloody fluid was obtained. Eleven of these patients had free acid present in the stomach. The amount of free acid present in each case is recorded as follows: 5°, 5°, 15°, 17°, 17°, 20°, 25°, 28°, 40°, 45° and 45°.

Free Hydrochloric Acid Present	No Free Hydrochloric Acid
11 patients	13 patients

DISCREPANCIES IN X-RAY INTERPRETATIONS

In three instances the roentgenologist reported "benign pyloric obstruction" when carcinoma of the stomach was found at operation; in one case "large extrinsic defect of pyloric antrum due to pancreatic tumor" was reported; at operation, inoperable carcinoma of the stomach was found.

DISPOSITION OF PATIENTS

Not operated upon	19
Operated upon	36
Exploratory only	12
Gastroenterostomy	4
Gastrostomy	1
Subtotal gastrectomy	18
Total gastrectomy	1

Of the number of patients undergoing no operation, none is known to have survived longer than five months.

Of the number undergoing exploratory laparotomy only, or a palliative operation, 5 died in the hospital, 12 are known to have died within five months postoperatively, and none is known to have survived longer than eight months.

SUMMARY OF PATIENTS HAVING GASTRECTOMY FOR CANCER OF STOMACH

(1) A 74 year old white male admitted Nov. 26, 1934, with the chief complaint of epigastric pain of 3 months' duration, and 38 lbs. weight loss. Epigastric mass felt. Hemoglobin 70%. Subtotal gastrectomy Nov. 28, 1934. Right lower lobe pneumonia developed and patient died Dec. 11, 1934. Autopsy obtained.

(2) A 56 year old white male admitted Aug. 17, 1940 with the chief complaint of epigastric pain of 8 months' duration. Weight loss of 16 lbs. Hemoglobin 42%. Subtotal gastrectomy Aug. 26, 1940. He was seen here Jan. 6, 1943 when an epigastric mass was palpable. Deep x-ray treatment advised. Returned Jan. 16, 1943. Lost to follow-up.

(3) A 62 year old white male admitted March 1, 1938, with the chief complaint of cramps in stomach of one year's duration. Weight loss of 27 lbs. Hemoglobin 66%. Subtotal gastric resection March 8, 1938. On Aug. 7, 1943, patient reported to be alive and working in lumber camp. Lost to follow-up.

(4) A 66 year old white male admitted Jan. 17, 1947, with the chief complaint of pain in stomach of 3 months' duration. Hemoglobin 87%. On Feb. 3, 1947, subtotal gastrectomy performed. Correspondence dated Feb. 13, 1950 states that patient is alive and free from pain, but very weak.

(5) A 76 year old white male admitted Oct. 27, 1943, with the chief complaint of aching in stomach of 10 months' duration, and 25 lbs. weight loss. Hemoglobin 66%. Nov. 1, 1943, had subtotal gastric resection performed. Patient expired Nov. 16, 1943. Autopsy revealed gangrene of the transverse colon, and peritonitis due to injury to middle colic artery.

(6) A 44 year old white female admitted July 3, 1944, with the chief complaint of misery in stomach and nausea and vomiting of 2 months' duration; weight loss of 39 lbs. Hemoglobin 72%. On July 11, 1944, subtotal gastric resection performed. Examination on March 31, 1945 disclosed a large epigastric mass. Lost to follow-up.

(7) An 82 year old white female seen here Jan. 5, 1945 with the chief complaint of epigastric distress of 3 months' duration, nausea and vomiting, and 45 lbs. weight loss. Hemoglobin 72%. On Jan. 9, 1945, subtotal gastric resection was performed. Correspondence dated Dec. 20, 1949 indicated patient alive and well.

(8) A 58 year old white male admitted April 23, 1945 with the chief, complaint of pain in stomach of 12 months' duration. Weight loss of 54 lbs. Large mass palpable in epigastrium. Hemoglobin 66%. On April 27, 1945, subtotal gastrectomy performed. Patient writes (Dec. 14, 1949) that he is getting along fine, and is working.

(9) A 39 year old white male admitted Aug. 19, 1946 with a history of having been treated for peptic ulcer since Oct. 25, 1945 by this hospital staff. He complained of pain, nausea and vomiting, with weight loss of 32 lbs. Hemoglobin 93%. On August 21, 1946 subtotal gastrectomy was performed. Postoperatively deep thrombophlebitis of left leg developed. He was reported by correspondence to be in good health on Dec. 19, 1949.

(10) A 44 year old white male admitted March 16, 1946, with the chief complaint of pain in epigastrium of 6 months' duration; weight loss of 16 lbs. Hemoglobin 48%. On March 25, 1946, subtotal gastrectomy and excision of part of transverse colon performed. Discharged April 10, 1946. Readmitted May 19, 1946 for treatment of obstruction of bowel, and died July 30, 1946.

(11) A 51 year old white female admitted April 11, 1947, with the chief complaint of epigastric pain of 5 months' duration. Weight loss of 50 lbs. Hemoglobin 12.5 Gm. On April 18, 1947, subtotal gastrectomy was performed. Patient re-examined Sept. 29, 1949, when two pelvic masses were felt. On Oct. 5, 1949, bilateral Krukenberg tumors were removed. No evidence of other metastases.

(12) A 58 year old white male admitted Jan. 22, 1947, with the chief complaint of weakness of one month's duration and weight loss of 15 lbs. Hemoglobin 45%. On Jan. 25, 1947, subtotal gastrectomy was performed. The patient reported for examination Jan. 23, 1950. Getting along fine, no evidence of recurrence or metastases.

(13) A 63 year old white male, admitted Feb. 18, 1947, with the chief complaint of epigastric pain of 6 months' duration, nausea, and weight loss of 19 lbs. Hemoglobin 66%. On Feb. 25, 1947, subtotal gastrectomy was performed. Patient states by correspondence dated Oct. 20, 1949 that he is getting along fine and has no complaints.

(14) A 66 year old white male admitted May 6, 1947 with the chief complaint of epigastric misery of 9 months' duration, with 18 lbs. weight loss. Hemoglobin 57%. Subtotal gastrectomy may 10, 1947. Patient writes (Oct. 17, 1949) that he is doing fine.

(15) A 76 year old white male admitted Oct. 16, 1947, with the chief complaaint of epigastric pain of 4 months' duration, nausea and vomiting, with 6 lbs. weight loss. Hemoglobin 78%. On Oct. 18. 1947, subtotal gastrectomy performed. The patient died Sept. 21, 1948. Autopsy showed mucinous carcinoma of stomach, with metastases.

(16) A 74 year old white male admitted May 22, 1948, with the chief complaint of pain in region of heart of 6 months' duration. Weight loss of 21 lbs. Hemoglobin 21.4%. On June 9, 1948 total gastrectomy was performed for extensive carcinoma of stomach. Patient expired at home July 8, 1949.

(17) A 58 year old white male admitted Jan. 10, 1949, with the chief complaint of epigastric pain of over 30 years. X-ray examination had shown an ulcer in 1942 and again in 1945. Weight loss of 12 lbs. Hemoglobin 88%. On Jan. 11, 1949, subtotal gastrectomy was performed. The patient was getting along fine according to a letter dated Oct. 20, 1949.

(18) A 63 year old white male admitted Jan. 15, 1948, with the chief complaint of abdominal cramps of one year's duration. "Stomach trouble" for 10 years. Diagnosed as having peptic ulcer Nov. 21, 1947. Weight loss of 8 lbs. Hemoglobin 93%. On Jan. 16, 1948, subtotal gastrectomy was performed. He was checked here by x-ray Aug. 25, 1949; no evidence of recurrence. Patient has no complaints.

(19) A 58 year old white male admitted Jan. 19, 1950, with the chief complaint of nausea and vomiting of 1½ months' duration. Weight loss of 15 lbs. Hemoglobin 62%. On Jan. 28, 1950, subtotal gastrectomy was performed. He is getting along fine so far.

SUMMARY

From July 26, 1933 to May 1, 1950, 55 inpatients with cancer of the stomach were treated in the Myers Clinic Hospital. Nineteen (34%) were not operated upon; 36 (66%) were subjected to operation, with only 19 (53%) of the latter group having definitive surgery (subtotal or total gastrectomy). This later group of patients is summarized as follows: Eleven patients are known to be alive at the present time, all but one stating that they are getting along fine, with no complaints.

BREAKDOWN OF GASTRECTOMY CASES

Case	Length of Time Patient Followed After Operation	Present Status	Remarks
1.	Died in hospital		Autopsy showed lobar pneumonia
2.	5 months	Lost to follow-up	When last seen an epigastric mass was palpable
3	5½ years	Lost to follow-up	Well and working when last seen
4.	3 years	Alive but very weak	
5.	Died in hospital		Autopsy revealed gangrene of transverse colon due to injury to middle colic artery
6.	9 months	Lost to follow-up	When last seen a large epigastric mass was present
7.	5¾ years	Alive and well	Working
8.	5 years	Alive and well	Working
9.	3¾ years	Alive and well	Working
10.	4 months	Dead	Died of intestinal obstruction
11.	3 years	Alive and well	Bilateral Krukenberg tumors removed 10-5-49
12.	3 years	Alive and well	Working
13.	3 years	Alive and well	Working
14.	3 years	Alive and well	Working
15.	Died in hospital		Autopsy showed carcinomatosis
16.	1 year	Dead	
17.	1 year	Alive and well	
18.	2 years	Alive and well	
19.	4 months	Alive and well	

IMPORTANCE OF MEDICAL HISTORY

Carefully taken, medical histories display a sequence of events similar to that of a detective story. The histories are saturated with clues and hints, if one takes advantage of them, which by skillful interrogation and dexterous coordination are molded into orderly arrangements that we identify as syndromes.

The detective story, likewise, presents a series of incidents also known as clues, which by logical reasoning, eventually terminate in the solution of the problem. The clues and hints offered in the medical history are technically known as symptoms. We realize, of course, that the detective narrative is far less complicated than the medical problem, but, in a general way, both are very similar in their objectives.—I. Robt. Frank, M. D., in American Practitioner.

Poliomyelitis is one of the world's oldest known diseases, having been recognized by the Egyptians as early as 1600 B. C.—R. N.

PROLONGED RELIEF FROM DYSPHAGIA FOLLOWING DILATION OF ESOPHAGEAL CARCINOMA

(Report of Case)

By EDWARD B. MEWBORNE, M. D.,
Newport News, Va.
and
PORTER P. VINSON, M. D.*
Richmond, Va.

Relatively few patients who have malignant esphageal tumors are acceptable for surgical treatment because of advanced age, general debility or evidence of extension of the growth beyond the confines of the esophagus. Recent progress in esophageal surgery has permitted more frequently successful resection of malignant tumors in a small selected group of patients, but in most instances early recurrence of the growth after operation obligates the surgeon to regard radical removal of the tumor as a palliative rather than a curative procedure.

Gastrostomy seldom is considered a palliative operation by those who have to care for patients with esophageal carcinoma after a tube has been inserted into the stomach for feeding purposes and, in the majority of patients, dilation of a malignant esophageal stricture remains the most effective method for providing palliative relief from dysphagia. This method of management is valuable not only in patients who are not considered suitable for operation but also in post-operative cases to overcome narrowing of the esophagus at the site of anastomosis with the stomach.

Dilation with sounds guided over a previously swallowed twisted silk thread is accomplished with a minimal amount of risk and discomfort, and relief from dysphagia may be prolonged after treatment. Subsequent narrowing of the area of obstruction can be enlarged by further dilations. Usually, periods of relief from dysphagia vary from six to eight weeks after dilation, but in some patients much longer intervals of comfort are provided. The following case is illustrative of the degree of palliation that may be obtained by dilation.

REPORT OF A CASE

A white man, aged 75 years, was admitted to the Medical College of Virginia Hospital November 22, 1948. He had been well until two months previously when he noted dysphagia while eating an apple. After this he had continuous difficulty in swallowing solid food although less trouble was experienced in drinking liquid or in eating soft food. Dysphagia had not increased in severity since the beginning of his difficulty, but there had been moderate loss of weight and strength.

Fig. 1. Roentgenogram showing obstruction in middle third of esophagus.

Roentgenoscopic study revealed an obstruction

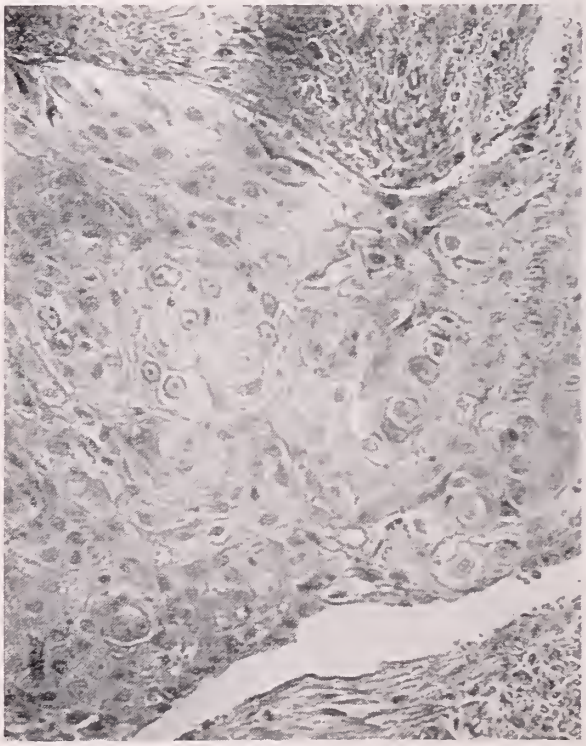

Fig. 2. Photomicrograph showing squamous cell carcinoma grade 2 of esophagus.

*Professor of Bronchoscopy, Esophagoscopy, and Gastroscopy, Medical College of Virginia.

in the middle third of the esophagus that was considered to be produced by carcinoma (fig. 1). Esophagoscopic investigation was not performed, but the stricture, which was located 11 inches from the incisor teeth, was dilated with a 45 French sound, and the patient returned home the following day.

For eight months following treatment there was complete freedom from dysphagia, and the patient was able to swallow all types of food without difficulty. During the next six months the patient noted slight dysphagia at times but otherwise felt quite well.

When he returned for re-examination March 30, 1950, he had gained 25 pounds in weight since his original visit fourteen months previously. The stricture was dilated again to size 45 French. Because miscroscopic proof of the presence of carcinoma had not been obtained previously, esophagoscopic examination was performed April 1, 1950, and an infiltrating lesion was observed in the middle portion of the esophagus. Tissue removed for microscopic study revealed squamous cell carcinoma grade 2 (fig. 2).

The patient was dismissed the following day with the instruction to return for further dilation when dysphagia recurred.

CANCER OF THE LUNG

In the interest of greater salvage from cancer of the lung, physicians should remember that its incidence is increasing more rapidly than any other form of cancer in males; that it is curable to a large extent when found in early stages; that, unfortunately in earliest stages, its signs and symptoms are so mild as to excite no suspicion of patient or physician in the majority of cases; that periodic chest x-rays may be necessary to establish the diagnosis; that cytological examination of sputum and bronchial secretions, along with biopsy, usually clinches the diagnosis; that pneumonectomy is the only treatment of curative value and then only in early stages; and that every male patient, 40 years of age or older with indefinite lung symptoms, should be considered a cancer patient until proved otherwise.—J. Michigan St. Med. Soc.

RIGHTS OF THE ELDERLY

The elderly should have the help of family and friends and the opportunity of being interesting to both family and friends. They are entitled to the right to have fun and friends, even to be romantic; to have hobbies, be interested in politics; to enjoy harmless gossip and to be normal human beings.

The aging individual has a right to a future. He can't live in the past, and he must be given every opportunity to look forward. He should be treated as a person—a grown-up person.

It should be kept in mind that years bring experience, and experience is an essential ingredient of wisdom.—New York Medicine.

A STUDY OF THE Q-T INTERVAL IN THE ADULT MALE*

By DON V. HATTON, M. D.
Oak Hill, W. Va.

The Q-T interval (electrical systole) has been shown to bear a constant correlation with the cardiac cycle length. Such factors as tachycardia from exercise do not alter this correlation.[6] Before we can say that a given Q-T interval is abnormal, it must be compared with the "ideal" Q-T interval that should theoretically occur with that particular ventricular rate. The calculation of the ideal Q-T interval involves the use of complicated formulas.

The ideal Q-T interval has been determined by the use of numerous formulas. The formula most commonly used, however, has been the one proposed by Bazett.[1] This formula is $Q\text{-}T = k\sqrt{RR}$. The factor RR is the measured distance between two successive R waves. The value for the constant k has been 0.40 in more recent studies. This value was assigned after it had been found by Taran and Szilagyi[3] that the value as chosen by Fenn[10] resulted in the placing of many normal Q-T intervals in an abnormal category. Bazett[1] has pointed out that the value of k as 0.40 is correct for men and children but incorrect with women.

The relation of the measured Q-T interval to the ideal Q-T interval can be described as a percentage or ratio. When expressed in this manner, it is possible to compare different Q-T intervals and to determine whether or not they are prolonged and to what degree. This comparison of the measured and "ideal" Q-T intervals can be termed the "Q-T ratio". Recently, Goldberger[4] has devised a nomogram that reduces the complicated calculations for determining the Q-T ratio to a few simple measurements. With the aid of this nomogram the R-R and Q-T intervals are measured and plotted on their respective scales. The Q-T ratio is then read directlly from a third scale.

Theoretically, any Q-T ratio above 1.00 is abnormal. Studies by Pokress and Goldberger,[5] and Ashman and Hull[2] indicate that the Q-T ratio in normal men occasionally may be as high as 1.08. These same observers have found that the "average normal" Q-T ratio is 1.01. These "normals" were used in Goldberger's recent study of the Q-T interval in acute rheumatic fever. Studies by Ashman and Hull,[2] Taran and Szilagyi,[3] and Pokress and Goldberger[5] have in-

*Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions of the author are the results of his own studies and do not necessarily reflect the opinions of the Veterans Administration.

dicated that the Q-T interval is frequently prolonged in acute rheumatic fever. Few studies have been made on the Q-T interval in the more chronic forms of heart disease.

METHOD

Electrocardiograms were performed on 602 veterans over fifty years of age who reported to the Veterans Administration Regional Offices for examination for pension purposes. The age distribution of these individuals can be seen in table 1. It is noted that 80 per cent of the veterans were actually over 55 years of age. These persons were studied for the presence of heart abnormalities and were classified as follows:

"Normal" Heart.—There were 250 persons in this group. Physical examination, fluoroscopy, x-ray and electrocardiograms revealed no evidence of cardiac abnormality. Subjective symptoms such as dyspnea et cetera, must be interpreted with care when compensation is involved. When leading questions are asked a great number of affirmative answers are received.

Hypertensive Heart Disease.—There were 127 in this group. Diagnosis was based on the presence of hypertension with evidence of cardiac abnormality which was thought to be secondary to the hypertension. Cases with a history of rheumatic fever and secondary hypertension were not included. In this particular age group arteriosclerosis undoubtedly played a part in some cases listed in the hypertensive group. An attempt was made to decide the chief etiologic agent. Questionable cases were not included.

Arteriosclerotic Heart Disease.—One hundred and twenty-five were included in this group. Diagnosis was based on the presence of cardiac abnormality without hypertension, a history of rheumatic fever, or other possible causes of heart disease.

"Uncomplicated" Hypertension.—One hundred individuals were found to have definite hypertension without demonstrable cardiac abnormality. Some of these cases probably had secondary cardiac changes but no clinical, fluoroscopic, nor electrocardiographic evidence of cardiac abnormality could be found.

All cases studied were ambulatory. Few objective findings suggestive of broken cardiac compensation were discovered, although most of those studied had indefinite symptoms such as shortness of breath, palpitation, et cetra. All electrocardiograms were taken with the patient in a reclining position. In most instances, only one electrocardiogram was recorded for each patient. All electrocardiograms were interpreted by the same person. Lead II was used for the required measurements and several cycles were measured. Measurements were made with the aid of low power hand lens and a sharp pointed divider. The nomogram of Goldberger was used in calculating all Q-T rations.

Table 1. Age Distributian af 602 Male Veterans Used in Study af Q-T Intervals and Ratias

Classification of Heart Disease	Age in Years 50-54	55-59	Over 60
"Normal"	56 (22.4%)	144 (57.6%)	50 (20%)
Hypertensive Heart Disease	21 (16.5%)	58 (45.6%)	48 (37.8%)
Arterio-sclerotic Heart Disease	29 (23.2%)	66 (52.8%)	30 (24.0%)
"Uncompli-cated" Hyper-tension	23 (23.0%)	53 (53.0%)	24 (24.0%)

Table 2. Q-T Ratias af 602 Male Veterans Examined far the Presence af Heart Disease*

Classification of Heart Disease	Q-T Ratia .80-.89	.90-.99	1.00-1.09	Over 1.10
"Normal"	17 (6.8%)	83 (33.2%)	137 (54.8%)	15 (6.0%)
Hyperten-sive Heart Disease	9 (7.0%)	32 (25.2%)	65 (51.0%)	21 (16.9%)
Arteriosclerotic Heart Disease.	13 (10.8%)	37 (29.6%)	54 (42.2%)	21 (16.8%)
"Uncomplicated" Hyper-tension	4 (4.0%)	30 (30.0%)	46 (46.0%)	20 (20.8%)

*Q-T Ratia—the ratia af actual Q-T interval to ideal Q-T interval.

RESULTS

The calculated Q-T ratios are recorded in table 2. From this table it is noted that the percentages of persons having Q-T ratios below 1.00 (the theoretical maximum normal) do not differ markedly in the several groups. Thus in the "normal" and "arteriosclerotic" groups about 40 per cent have Q-T ratios below 1.00. The percentages of individuals having Q-T ratios above 1.10, however, differ. In the normal group 6 per cent have Q-T ratios above 1.10 while 16-20 per cent of those having cardiovascular abnormalities have Q-T ratios above 1.10.

In recent studies by Goldberger,[5] 1.01 has been suggested as an "Average Q-T ratio" and 1.08 has been suggested as a "maximum normal Q-T ratio". These figures have been proposed as standards for men and children. When these "standards" are applied to our results we have the distribution noted in table 3.

Forty-three per cent of those cases with no demonstrable cardiac pathology had Q-T ratios above the "average normal" of 1.01. Seven and six-tenths per cent of this same group had Q-T ratios above the "maximum normal" of 1.08.

Table 3. Distribution of Cases According to "Standard" Q-T Ratios*

Classification of Heart Disease	Q-T Ratios Above 1.01 "Average Q-T Ratio"	Q-T Ratios Above 1.08 "Maximum normal"
"Normal".....	107 (42.8%)	19 (7.6%)
Hypertensive Heart Disease....	70 (55.0%)	23 (18.1%)
Arteriosclerotic Heart Disease....	65 (52.0%)	27 (21.6%)
"Uncomplicated" Hyper-tension.....	52 (52.0%)	23 (23.0%)

*Q-T Ratio—the ratio of actual Q-T interval to ideal Q-T interval.

In the groups with cardiac abnormality or "uncomplicated" hypertension about 52-55 per cent had Q-T ratios above the average normal of 1.01 and 18-23 per cent had Q-T ratios above the "maximum normal" of 1.08. There appeared to be no correlation between the high Q-T ratios and the severity of the cardiac abnormality. Thus in the group of uncomplicated hypertension 23 per cent had Q-T ratios above 1.08 while only 18 per cent of those with definite arteriosclerotic heart disease fell in this category. It was also interesting to note that some cases with no demonstrable cardiovascular pathology had extremely high Q-T ratios (above 1.15). In other instances those with marked electrocardiographic abnormality had Q-T ratios below 1.00.

DISCUSSION

Cases referred for cardiac examination seldom had specific diagnoses. Many were referred with diagnoses of "myocarditis", hypotension, et cetera. Most of the cases were referred with the hope that the cardiologist would find some cardiac abnormailty that would qualify the veteran for a pension. Actually a large percentage of all veterans reporting for any type of examination received a cardiac study. Such a group should not differ markedly from a segment of the ordinary male population in the same age group. Because of the inherent weaknesses of material of this type where pathologic studies are not available, it is believed by the author that statistical analysis is not justified. Thus some of our "normal" group might have had cardiac abnormalities that could not be demonstrated by the means available. Likewise, it is practically impossible to separate the arteriosclerotic factor from the group where the prime etiology appears to be hypertension. Without applying strict statistical methods we probably can reach some general conclusions.

If we accept the previously accepted standards of "average normal" and "maximum normal", we immediately place large numbers of individuals with no clinical or laboratory evidence of heart disease in a questionable category. Thus 42 per cent of our normals have Q-T ratios above the average normal and 7.6 per cent have ratios above the maximum normal. It is, of course, quite possible that there is no correlation between the cardiac pathology and the Q-T interval. Also, as stated previously, our "normals" may not be entirely normal from a cardiac standpoint, even though we were unable to demonstrate abnormalities. What appears more likely, however, is that our standards do not apply to this group. Perhaps Q-T intervals as previously determined and applied to "children and men", are not applicable to older males. The Q-T interval in older males might normally be prolonged, thus accounting for the large Q-T ratios. If such is the case, large series of males without cardiac disease must be studied to set a new standard of "normal". The fault may go back to the Bazett formula, and the accepted constant of 0.40 may be faulty.

Recent studies by Goldberger reveal that 28 per cent of his active cases of rheumatic fever had Q-T ratios above the maximum normal of 1.08. From our studies we were somewhat surprised to learn that 18-23 per cent of our cases of chronic cardiac abnormalities also had Q-T ratios above the maximum normal of 1.08. Furthermore, 42 per cent of Goldberger's cases had Q-T ratios above 1.01 at some time during their illness. In our studies 42.8 per cent of those without demonstrable heart disease had Q-T ratios above 1.01. Our group of cases with demonstrable cardiac abnormality demonstrated 52-55 per cent with Q-T ratios above 1.01. A comparison of these results seems to point even more strongly to the difference of "normal" standards that must exist in the older male when compared with the standards of the child and young adult.

In a very rough way our studies seem to indicate that a Q-T ratio of 1.08 plus is three times as likely to occur in individuals of this age group when cardiovascular abnormality is present as compared to the normal individual. Such a finding might be of value in reaching a conclusion in questionable cases when objective evidence is minimal. The author feels that the measurement of the Q-T ratio might prove of definite value when more complete studies are made to establish "normals" for this age group.

SUMMARY

1. Electrocardiograms were performed on 602 males over 50 years of age; Q-T intervals were measured and Q-T ratios calculated with the aid of the nomogram suggested by Goldberger.

2. Individuals were classified according to the presence or absence of heart disease. Studies and classification were based on physical examination, fluoroscopy, x-ray and electrocardiography.

3. A large per cent (42%) without cardiac disease had Q-T ratios above the "average normal" of 1.01 suggested by other writers.[5] These results do not differ markedly from results reported regarding prolonged Q-T intervals in persons with acute rheumatic carditis.

4. It is suggested that previously proposed "normal" Q-T ratios for children and men are not applicable to the older age groups. Further studies to establish a baseline are suggested.

5. The author suggests that the routine measurement of the Q-T interval and ratio might prove helpful if the limits of normal are more clearly defined. In this small study Q-T ratios above 1.08 occurred three times as frequent in individuals with demonstrable heart abnormality, when compared with individuals without demonstrable heart abnormality.

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USE OF HORMONES IN SCHIZOPHRENIA

Promising results in the treatment of schizophrenia, manic depressive psychosis and involutional psychosis with a combination of the two hormones, testosterone and estradiol, have been reported at the Creedmoor State Hospital, Queens, N. Y. The reporting psychiatrists base their theory on the supposition that an imbalance of hormones causes defects in the metabolism of the nervous system, thus causing many of the severe psychoses.—R. N.

DR. HENCH AND CORTISONE AND ACTH

Dr. Philip Hench had to wait seven years—from 1941 to 1948—to vindicate his conviction that there exists in nature an antirheumatic substance "X." In the last fortnight he has been in Britain, telling eager audiences of the swift march of events since he and his colleagues discovered the effect of "Cortisone" on rheumatoid arthritis.

Elsewhere we print in summary one of his lectures. In this, and in his address to the Royal Society of Medicine on Oct. 10, he made it clear that hitherto he has used neither cortisone nor adrenocorticotropic hormone (A.C.T.H.) in routine treatment. Their effects, he insisted, are transient. In acute rheumatic fever, for example, premature withdrawal of the drug may be followed by relapse up to the time when the active stage comes to its natural end.

The value of these hormones is likely to be greatest in the self-limiting diseases—notably rheumatic fever—and in some other disorders where, by tiding the patient over a crisis, they may save his life.

At the Mayo Clinic cortisone has been found to control inflammatory conditions of the eye, particularly those associated with rheumatic disease; and at the Royal Society of Medicine Dr. Hench reported that remarkable reduction of symptoms and signs had been observed in uveitis, iritis, and iridocyclitis. In a case of uveitis advantage has been taken of this temporary abatement to operate for concurrent glaucoma.

One surprising development is the discovery that cortisone seems to be effective when given by mouth in doses comparable to those injected parenterally; and trials of oral administration are proceeding at the Mayo Clinic. Growing experience is also bringing growing knowledge of dosage and side-effects. In general, abrupt termination of cortisone treatment is to be abjured; otherwise in rheumatoid arthritis a "rebound" relapse may be evoked. This can be averted by gradually tapering off the dosage or by replacing, towards the end of treatment, cortisone (which inhibits adrenocortical activity) by A.C.T.H. (which stimulates such activity).

Among the side-effects singled out by Dr. Hench for special mention are retention of fluid, impaired carbohydrate tolerance, major changes in the psyche, and spontaneous fractures. When side-effects are troublesome, either hormone might, he suggested, be best given in smaller doses than those which would restore the blood-sedimentation rate to normal or even completely suppress the symptoms.

These substances act, not against the "pathological anatomy," but against the "pathological physiology"; so the earlier they are given the better. In diseases where they are effective, they provide susceptible tissues with a "seal-like buffer" against the attacking irritant. "They do not put out the fire," Dr. Hench declared. "They do not act like a carpenter who repairs the damage after the fire. But they do provide an asbestos suit." How they act is still unknown, but this much is clear: "We must learn how to cooperate with, rather than dominate and supplant, the pituitary-adrenocortical mechanisms."—The Lancet.

TUBERCULOSIS ABSTRACTS*

The number of cases of unsuspected tuberculosis in the general population would be greatly reduced if physicians would require chest x-rays as a part of the routine examination of all private patients. Now as always, the physician in private practice is a key figure in the control of tuberculosis.

CASE FINDING AMONG PRIVATE PATIENTS

It is recognized that there are many reasons for the rapid decline in the incidence of tuberculosis during the past 50 years. It is impossible to evaluate accurately, or even approximately, the relative influence of complex socioeconomic conditions and of control measures in bringing about this favorable result.

In 1937, Wade H. Frost concluded that the point had been reached in the United States where there is a gradual downward trend in the incidence of tuberculosis, and that, barring major upsets in civilization, the eventual eradication of the disease can be expected. The continued decline in the annual number of deaths from tuberculosis during the past 12 years, in spite of the adverse conditions caused by a great war, is ground for confidence in the accuracy of Frost's conclusion.

Even though control measures are only one factor in the eradication of tuberculosis, they may very well be the decisive factor. Anything which will reduce the size of the reservoir of the tubercle bacillus in human beings will lessen the number of new cases of tuberculosis. Every case of the disease, actually or potentially infectious, which is discovered and brought under control is a step in reducing the size of this reservoir. In the aggregate, control measures may represent the weight which will tip the balance in favor of the human race. It is this consideration which gives importance to any method which discloses a considerable number of cases of tuberculosis, and especially of those which are symptomless.

Although statements to the contrary have been made recently, nothing is more completely proved than the fact that approximately one-half of all cases of significant tuberculosis have no symptoms, or symptoms so slight as to escape notice. According to the National Tuberculosis Association estimates, there are a quarter of a million unknown cases of tuberculosis in the United States—at least as many as there are known cases—and recent experience indicates that the unknown cases far outnumber the known. In the 1948 mass survey in Washington, D. C., 4,098 out of 4,665 cases of tuberculosis discovered were previously unknown to the health department. Similar findings have been reported in all other large surveys.

From its small beginnings during the decade 1930-40, the mass survey method for tuberculosis detection has advanced in the United States to the point where at present about 14 million people annually undergo chest x-ray examinations. This is a significant achievement, and although it can be extended until the equipment already existing is fully utilized, it still does not represent a case-finding rate sufficiently high to insure control of the disease in any reasonable time. It is important that the mass survey programs be enlarged, but, in the meantime, every method which promises disclosure of a considerable number of cases of tuberculosis should be utilized.

Sixty to eighty million Americans, for one reason or another, annually consult a doctor, and it is known that the tuberculosis rate among them is much higher than among the general population. For this reason it is highly desirable that private physicians, including general practitioners, internists, and specialists, obtain a survey film of every patient who consults them unless the results of a recent chest x-ray survey are available.

It has been the practice of some radiologists for many years to make a single film of the chest in cases referred for other examinations, especially in cases referred for gastrointestinal study. This has disclosed many unsuspected chest conditions including tuberculosis. Now that photofluorography has greatly reduced the cost of such a survey film it should become routine practice among radiologists; its quite nominal cost can be absorbed in the major examination.

This reservoir of cases, however, is small compared with the vast number who consult general practitioners and internists. Methods can undoubtedly be devised whereby all such patients, at least those who are 15 years of age or older, can have a survey film made without cost to the patient—even a small charge would probably prevent wide use of the method. It is not necessary that any one method be adopted to accomplish the desired end. In some communities, the local or state health department could, perhaps, defray the cost as part of the general tuberculosis prevention program, especially in view of the fact that case finding in the smaller group would be relatively much more productive than in the usual mass survey. In other communities, it could be done by the tuberculosis association. In still others, general hospitals which have adopted a hospital admission x-ray survey program could enlarge the program to include survey films for the private patients of members of the hospital staff. Furthermore, it could very well become general practice among radiologists to make available such service to the general profession.

The details of such a program may seem numerous and difficult at first thought, but they can be worked out. The first essential for its success is the interest of the private physicians of each community. They are in the best position to promote it and to carry it out.

Today, because of procedures which have become routine, the private physician's office is a bulwark against such diseases as smallpox and diphtheria. In like manner, it can become one of the most effective agencies for tuberculosis control. By promoting such a public health measure, the general practitioners of the nation would be acting in line with the great tradition of the profession as a force for prevention as well as cure of disease.—Case Finding Among Private Patients, A. C. Christie, M. D., Pub. Health Rep., June 2, 1950.

*Issued monthly by the National Tuberculosis Association and furnished through the courtesy of The West Virginia Tuberculosis and Health Association.

The President's Page

In a sense, this is my valedictory, which the dictionary defines as "a parting address." Yet, while it is true that this is my final President's Page, there will be no lessening of interest on my part in the affairs of the West Virginia State Medical Association. Indeed, as the new chairman of the Council, my duties will probably be more exacting than has been the case during the year that I have served as president.

No experience in my entire lifetime has been more interesting for me than my term as president of the State Medical Association. It has given me the opportunity to meet and know hundreds of members of the medical profession whom I have heretofore known by name only. What success I may have achieved as head of this progressive group is due to the splendid cooperation of our members to help make 1950 one of the banner years in our history. It would not have been possible for members of our profession to have done more to help me in my work. This I appreciate and shall remember always most pleasantly down through the years.

Frank J. Holroyd will take over as president on January 1, 1951. I pledge to him wholehearted cooperation during his term of office. Success to him and to the progressive program he will shortly unfold for the consideration of our members, who, I am sure, will give him the same full measure of support during his term that it has been my good fortune to have had during the past year.

From the very bottom of my heart, I thank all of the members of our Association for their helpful cooperation and assistance during my term as president, which for me has covered far too short a period of time, but which has helped me to understand much better the problems with which we are faced in these critical times.

C. E. Watkins

President.

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DOCTOR WILKINSON HONORED

All of the members of the West Virginia State Medical Association will be pleased to know of the high honor that has been accorded one of our past presidents, Dr. Robert J. Wilkinson, of Huntington, by the Southern Medical Association. He was named president elect at the annual meeting in St. Louis, November 14.

Long active in the affairs of the second largest medical group in the United States, Doctor Wilkinson is qualified in every respect to discharge the duties of his new office. He has held many offices in the West Virginia State Medical Association, and was honored by being elected president in 1942, completing his year's service December 31, 1943.

He has long been interested in and an advocate of increased facilities for medical education in West Virginia. He had much to do with arranging the program for the acceptance of twenty students annually from West Virginia University by the Medical College of Virginia for the completion of their third and fourth years in medicine.

Doctor Wilkinson was also instrumental in having created as one of our key committees a Fact Finding and Planning Committee, the name of which has been changed to "Fact Finding and Legislative Committee."

His service as a member and chairman of the council of the Southern Medical Association has fitted him for the important duties of the office of president. We congratulate him and all of the members of Southern Medical upon his election as president of the Association. He will carry with him to this important office the very best wishes, not only of the doctors in West Virginia, but the members of the profession in every state comprising the Association.

CHRISTMAS SEAL TIME

Christmas Seal time is here. Funds raised from the sale of seals constitute the only source of revenue of the West Virginia Tuberculosis and Health Association to carry on the fight against tuberculosis in all of the 55 counties in West Virginia.

Mr. Paul M. Lowther, of Clarksburg, president of the Association, has stated that 94 per cent of the total amount raised from the sale of seals will remain in West Virginia. The other 6 per cent will be used for research purposes and for the support of the tuberculosis fight on the national level.

During 1949, through the cooperation of the Association with the State Department of Health, the Bureau of Tuberculosis Control, local health departments and local tuberculosis associations, 113,244 persons had chest X-rays. As the result of this work, 2502 new cases of tuberculosis were found, reported, and diagnosed.

Much progress has been made, but there must be no let-up if we are to control tuberculosis as a major medical and socio-economic problem.

Each year over 20 million Americans buy Christmas Seals, the messengers of good health. We know that the members of the West Virginia State Medical Association will lend their full support to the program in 1950.

FROM WAY DOWN UNDER

After 12 years of operation, New Zealand's widely hailed "social security" medical plan is collapsing under its own weight, a regular correspondent of the Journal of the American Medical Association reports. Writing from Brisbane, Australia, for the issue of November 4, he cited the annual report of Dr. Duncan Cook, director of clinical services, to the New Zealand Parliament. In that report, Doctor Cook said:

"Increases in the cost of general medical services and pharmaceutical supplies have been of

such magnitude as to lead to serious misgivings as to whether state medical insurance against sickness is practicable or whether the best method of payment for services has been adopted."

Proponents of socialized medicine in this country have been pointing to the New Zealand program as an example of what government medicine can do, always omitting consideration of the Maoris in vital statistics reports.

The Journal correspondent said that in 1938 after a period of economic depression, the people of New Zealand welcomed the scheme "with its free medicine, free hospitalization and nominal payments for medical attendance."

However, the correspondent adds that "the original humanitarian concept has become a political football. Year by year benefits have been increased as a bait for the electors, until today the cost of social security is the biggest item in the national budget. In its last term of office last year, the labor government appealed to the New Zealand branch of the British Medical Association to stop the abuses and arrest the drift. One of the problems concerns 'shopping.' If the doctor does not satisfy the patient in what he feels are his prescription needs, he will go to a more obliging doctor. The government is now considering a nominal fee for each prescription, but the major problem remains to be solved."

Doctor Cook in his report to Parliament concludes that "unless the desired reforms made possible by the new legislation last session provide satisfactory remedies, the present system of social security medicine in New Zealand will either have to be modified considerably or replaced by a system more readily controllable."

In the same letter, the Australian correspondent reports an address by Mr. Colin Clark, probably the outstanding economist of Australia today, in which Mr. Clark says:

"The basic task of politics is to encourage and develop human responsibility. Nobody should be provided with any money or service for which he could have made adequate provision for himself with a reasonable exercise of responsibility and forethought. One of the first responsibilities of any man is to maintain his own health and that of his family, choosing doctors whom his experience and that of his friends tell him to be diligent and reliable.

"Medical services of all kinds in Australia cost about 4 per cent of the national income . . . Some system of medical insurance is extremely desirable . . . The practical problems of any system of insurance which will not be open to malingering . . . or to neglect of health are extremely difficult. Once we devise the right type of medical insurance . . . we get proper effects on incentive—both on the incentive to work and the incentive to save . . . In medicine, of all things, a rigid uniformity is the last system we should desire."

Such reports and the results of their last year's elections convince us that the Anzacs are beginning to realize that "all is not gold that glitters."

ABILITY RECOGNIZED

Mrs. V. Eugene Holcombe, of Charleston, long active in the affairs of the Woman's Auxiliary to the West Virginia State Medical Association, has again been elected to high office in the second largest Auxiliary group in the United States. She was named president elect of the Auxiliary to Southern Medical Association at the annual meeting held at St. Louis in November. This is most pleasing news to Auxiliary members in West Virginia and in the Southern Medical territory where she is so well known.

A past president of the Woman's Auxiliary to the American Medical Association, Mrs. Holcombe has a country-wide acquaintanceship that will mean much to her when she assumes her duties as president of the Southern Medical Auxiliary. She has always been interested and active in the work of the Auxiliary whether it concerned her local group or the state or national group.

We extend heartiest congratulations to her upon the recognition of her ability in this large field by delegates to the Auxiliary meeting in St. Louis. She will take office with the best wishes of the Auxiliary and the members of the West Virginia State Medical Association.

LET'S PRESERVE OUR FREEDOM

The following is part of an editorial that appeared in the October 17 issue of the Clarksburg Telegram. While the editorial appeared too late to permit its reproduction in the November issue of the Journal, we feel that it is "must" reading for our doctors even though the 1950 election is history.

The editorial follows:

"Far-reaching effects have come from an address by U. S. Sen. John L. McClellan, of Arkansas, on socialized medicine at a meeting sponsored here by the Harrison County Medical Society. Sen. McClellan pointed out the dangers of socialized medicine currently being practiced in England and

Russia. All that is necessary is to let the American public know how the plan works and what effect such Russianized action would have on our country and our people. They will then see to it that any such Communistic setup is defeated.

"The medical world as a rule has not shown any great interest in politics, due possibly to the fact it was engaged during World Wars I and II in saving lives at the front and in the many veterans hospitals as well as taking care of the home front. The medical profession can be proud of its great contribution in winning our wars; it worked night and day in saving lives of our men and quite often the lives of the enemy when captured.

"In some parts of the world an organization was formulated with the object of destroying the medical profession: First, in England and then in the United States. Due to the fact the present administration furnished billions of dollars to believers of Socialism in England, the Churchill government was defeated. Now that once great country is suffering under the burdens of socialized medicine and industry (which will include the steel industry within a short time).

"Now England is on the begging list, seeking more billions from our taxpayers to maintain her army and navy as well as all socialized branches there.

"The recent convention held in California by the doctors of the nation was memorable in that the president of this great organization made an excellent speech outlining the present situation and dangers. If the fight is continued in every district and every state, these Reds will not elect enough members to put through socialized medicine the coming year.

"There is no question that the present administration is following the socialized road of Britain and the Red road of Russia in some respects. The one sure way of defeating any such trend is for the women to take an active part. No real American woman will tolerate a Red as her doctor or doctor of her family. Communism in any shape or form is directly opposed to American principles and traditions . . .

"If the American people want to live under Communist control with socialized medicine and socialized everything else, they may have an opportunity to do so unless they elect officials who believe in Americanism and will vote for the preservation of our freedom and ideals."

OUR GREAT NEED

One of the great needs of West Virginia today is a four-year medical and dental school. Thus far most of the support for such an institution has come from the medical association which has been campaigning for such an establishment for the past two years.

It is time the people of the state realize the importance to their welfare of having a four-year medical and dental school in this state. Many young doctors and dentists, upon completing their work in out-of-state schools are entering practice elsewhere. A general shortage of doctors and dentists in other states as well as West Virginia, promises to become acute in this state.

Location of the medical school has been the bone of contention heretofore in discussions concerning its establishment. The location should be determined by the experts as that providing the best facilities and services in the most economical manner. But the people should inform their legislators now of their desire for the establishment of such an institution.—The Weston Democrat.

GENERAL NEWS

ESTABLISHMENT OF FOUR-YEAR SCHOOL AGAIN URGED BY HOUSE OF DELEGATES

The House of Delegates of the West Virginia State Medical Association, at a special meeting at the Stonewall Jackson Hotel, in Clarksburg, November 19, 1950, again went on record unanimously in favor of the establishment in this state of a four-year school of medicine and dentistry as a part of West Virginia University. Resolutions urging the creation of the school had previously been adopted at regular sessions of the House of Delegates in August, 1949, and July, 1950.

The special meeting was called by the president, Dr. Charles E. Watkins, of Oak Hill, upon petition of 25 members of the House, and when the roll was called at the opening of the session, 77 members answered to their names. The roll call shows that, besides the officers, 7 of the 21 living past presidents, and 67 regularly elected delegates from the 29 component societies were present.

It was the first called meeting of the House of Delegates in recent years, and was one of the most largely attended meetings ever held by the Association.

Legislators Approve School

The need for a special meeting to try to iron out differences before the next meeting of the Lgislature in 1951 was emphasized more fully with the publication of a news story to the effect that over 80 candidates for seats in the West Virginia Senate and the House of Delegates had gone on record as favoring the establishment of a four-year school. Of the 84 candidates who expressed approval of the project, 45 were elected at the general election on November 7, and the increase of interest among members of the Legislature, including some hold-over senators, no doubt was responsible for the requests for a special session of the Association's House of Delegates to chart a course of action in connection with any proposal for the construction of a school that may be considered by the Legislature next January.

Location Not Considered

At the three-hour session of the House of Delegates, the matter of the establishment of the school was discussed from practically every angle with the exception that the question of location did not enter into the debate to any great extent.

It seemed to be the desire of the delegates present to have the matter submitted to the Legislature without rcommendation as to location, but with the recommendation that the school be a part of West Virginia University.

Resolution Unanimously Adopted

The following resolution, offered by Dr. D. A. MacGregor, of Wheeling, chairman of the Association's

Fact Finding and Legislative Committee, was unanimous adopted:

WHEREAS, The desirability and the necessity of establishing a four-year medical school and a dental school in the State of West Virginia is widely recognized by the people of West Virginia, and it has been emphasized by repeated statements issued by the Council of the West Virginia State Medical Association during the past twenty-nine years and by a recent statement issued by the Board of Governors of West Virginia University; and,

WHEREAS, An Interim Committee was created by the last legislature (1949) to "make a study and survey concerning the advisability of the establishment of a four-year school of medicine and dentistry of West Virginia University, the proper location of such a school, and the cost and adequate financing thereof":

NOW, THEREFORE BE IT RESOLVED: That the House of Delegates of the West Virginia State Medical Association desires to emphasize its previous recommendations for a four-year medical school and dental school;

That the legislature be urged to provide adequate funds for the establishment and maintenance of a first-class institution of this kind; and,

That it is the feeling of the House of Delegates that the Legislative Interim Committee has assembled sufficient factual data to enable it to report accurately to the legislature with respect to:

1. The probable cost of establishment and maintenance; and,
2. The proper location for the institution where state funds can be spent most economically to secure the best possible facilities and greatest benefits for the largest number of our citizens.

Recommends School Be Part of University

After the adoption of the resolution, a motion made by Dr. Sobisca S. Hall, of Clarksburg, that the House of Delegates recommend that the proposed medical and dental school be created as part of West Virginia University, was unanimously adopted.

Board of Governors Recommends Expansion

During Doctor MacGregor's presentation of the proposal for reaffirmation by the House of Delegates of its position in favor of a four-year school, he submitted for consideration by the delegates present a copy of the resolution adopted by the Board of Governors of West Virginia University at a special meeting at Weirton, on October 27, 1950, which copy was furnished to him by Mr. William G. Thompson, of Montgomery, president of the Board. The resolution follows:

"The West Virginia University Board of Governors recommends the immediate expansion of the University's present two-year medical school into a four-year medical and dental school, teaching hospital, nurses training school and state health center, on the campus of the University at Morgantown.

"Our study upon which this recommendation is based shows that the required capital expenditures for this program are:

(a) Teaching Building (This building will replace the building now used for the two-year medical school which for some time has been totally unsuited even for the two-year school.)	$2,500,000.00
(b) Teaching Hospital	6,000,000.00
(c) Quarters for student nurses	700,000.00
	$9,200,000.00

The annual cost of operation will be:

Minimum	$ 750,000.00
Maximum	$1,000,000.00

"The Board further recommends that the Executive and Legislative branches of the state government develop forthwith sound means by which funds shall be made available to put this recommendation into early effect, without prejudice to the continued improvement and development of the other presently existing colleges, schools, departments and services of the University as recommended by the Board."

Deans' Reports Discussed

Dr. Thomas L. Harris, of Parkersburg, a member of the Board of Governors, as well as a member of the House of Delegates, discussed the resolution adopted at the meeting at Weirton, expressing the hope that, with the aid of members of the State Medical Association, it will be possible to get an initial appropriation from the Legslature of sufficient funds to construct a teaching building for a medical school during the next two years.

Doctor MacGregor and several members of the House of Delegates discussed the reports filed by Dr. Herman G. Weiskotten, of Syracuse, New York, Dean of Syracuse University College of Medicine, and Dr. Wilburt C. Davison, of Durham, North Carolina, Dean of Duke University School of Medicine, in connection with the proposed four-year school.

The two deans were requested by the Legislative Interim Committee to make independent surveys in West Virginia concerning the need for such a school. Reports were submitted during the summer of 1950, and were published in full in the July, 1950, issue of the West Virginia Medical Journal. Both Dean Weiskotten and Dean Davison advocated the immediate construction of a four-year school in this state.

Legislative Interim Committee Makes Study

The Legislative Interim Committee, created under the provisions of Senate Concurrent Resolution No. 9, adopted March 2, 1949, provided that the Committee "be created to make a study and survey concerning the advisability of the establishment of a four-year school of medicine and dentistry of West Virginia University and the proper location of such a school when established, taking into consideration the general public health program of the State, and the furnishing of the best possible training for doctors, dentists and nurses."

The resolution further provided that "prior to the convening of the next regular session of the Legislature, the Committee make and issue a report to the Governor and to the Legislature concerning its study, together with such recommendations and proposed legislation as may in its opinion best serve the best interests of all the people of the State."

The resolution further authorized the Governor to appoint an advisory committee to consult and advise with the Interim Committee "concerning the best solution of the problem."

Personnel of Committees

Senate President, W. Broughton Johnston, of Princeton, and House Speaker W. E. Flannery, of Logan, are co-chairman of the Interim Committee. The other Senate members are Don J. Eddy, of Morgantown; Dr. Ward Wylie, of Mullens; A. L. Reed, of Newburg; and Theodore M. Bowers, of New Martinsville.

House members are Mrs. Nell W. Walker, of Winona; Robert E. Roach, of New Cumberland; H. Hayden Morgan, of Adrian; and J. Allen Overton, of Parkersburg.

The advisory committee appointed by Governor Okey L. Patteson is composed of Dr. Irvin Stewart, of Morgantown, president of the University; Dr. Thomas G. Reed, of Charleston, immediate past president of the State Medical Association; Dr. W. W. Curry, of Holden, past president of the State Dental Society; and Leada Neininger, R. N., president of the State Nurses Association, all ex officio members; and, Martha Woodell, R. N., of Clarksburg, immediate past president of the State Nurses Association; Clarence Martin, Jr., attorney, Martinsburg; Dr. Donzie Lilly, Athens, past president of the State Dental Society; Dr. D. A. MacGregor, Wheeling, chairman of the State Medical Association's Fact Finding and Legislative Committee; Dr. Thomas Bess, Keyser, past president of the State Medical Association; and John T. Johnson, Williamstown, master of the West Virginia State Grange.

Committees Expected to Report

The next regular session of the Legislature will convene at Charleston, Wednesday, January 10, 1951, and, if the usual procedure is followed, the report of the Interim Committee will be submitted to the Governor and the Legislature early in the session.

STATE DOCTORS NAMED FELLOWS BY ACS

Nine West Virginia doctors were elected fellows of the American College of Surgeons at the annual meeting held in Boston late in October. They are J. A. Kyle Bush, Philippi; Russell Smith Coffindaffer, Shinnston; Albert C. Esposito, Huntington; Isabelle Harrison, Martinsburg; Carlisle Bee Hughes, Jr., Montgomery; James Richmond Low, Princeton; Athey R. Lutz, Parkersburg; John James Sherman, Huntington; and James Edward Wilson, Clarksburg.

A total of 978 initiates were received into fellowship at the meeting. This was the largest class since 1914.

STATE GRANGE FOR FOUR-YEAR SCHOOL

At the annual meeting of the West Virginia State Grange, held at Jackson's Mill, October 25-27, 1950, the following resolution with reference to the proposed establishment of a four-year school of medicine and dentistry in West Virginia was adopted:

"We, the West Virginia State Grange request our legislature to establish a four-year medical and dental college, along with a hospital to help take care of our great demand and need for medical and dental care. We favor this being centrally located in our state. We feel this is a very urgent need."

DR. R. J. WILKINSON PRESIDENT-ELECT OF SOUTHERN MEDICAL ASSOCIATION

Dr. R. J. Wilkinson, of Huntington, was named president elect of the Southern Medical Association at the annual meeting in St. Louis, November 14, 1950. He has just completed a term as first vice president of the Association. He was a member of the Council for several years, and has served as its chairman.

Doctor Wilkinson was a member of the Council of the West Virginia State Medical Association for four years and served as president in 1943. He was chairman of the Council the following year, and has served as chairman of various key committees of the Association for the past several years.

In addition to the many honors accorded him by the profession in West Virginia, Doctor Wilkinson has served as president, respectively, of the Southeastern Surgical Congress and the Chesapeake & Ohio Railway Surgeons' Association. He is a diplomate of the American Board of Surgery, and a fellow of the American College of Surgeons and the International College of Surgeons. He has been surgeon in charge of the C. & O. Employees' Hospital, at Huntington, since 1915, and is chief surgeon at the Wilkinson Surgical Clinic in that city.

Doctor Wilkinson is the third West Virginia doctor to be elected president of the Southern Medical Association. Two other Huntington doctors, Thomas W. Moore, and Walter E. Vest, have held that office.

AMERICAN LONGEVITY NEAR WORLD'S BEST

The gains in longevity among the American people have been so large in the past few decades that the average length of life of our white population is now close to the best in the world.

Near the beginning of the century, in 1901-1910, the expectation of life at birth among white persons in the United States averaged 6 years less than in Australia and 9 years less than in New Zealand, the two countries which have long been in a foremost position among the nations with respect to longevity.

By 1947, our expectation of life was within ¾ of a year of Australia's and 1¾ years of New Zealand's. For white females alone the difference was even less, namely, 2/5 of a year and 1 year, respectively.

Between 1901-1910 and 1947, the expectation of life at birth in our country increased 16 years for white males and 18 years for white females. In Australia the corresponding gains were 11 and 12 years, and in New Zealand a little over 9 years and 10½ years.—Statistical Bulletin, Metropolitan Life Insurance Company.

PERSONALIZATION OF MEDICAL SERVICE

The practice of medicine is not merely a transfer of scientific knowledge and skill to the patient in line. Interwoven and highly essential for its effectiveness is the personalization of the service and the willingness of the individual physician to place his own comfort and convenience last. In that service lies the effectiveness and appeal of our present system and through it can be mustered the strength to stall the efforts of those who would discard it.—Wm. S. Reveno, M. D., in Detroit Medical News.

SOUTHERN MEDICAL AUXILIARY NAMES MRS. V. E. HOLCOMBE PRESIDENT ELECT

Mrs. V. Eugene Holcombe, of Charleston, was named president elect of the Woman's Auxiliary to the Southern Medical Association at the annual meeting held in St. Louis, November 13-16, 1950. She will be the second member of the West Virginia Auxiliary to be elected president of the Southern Medical group. Mrs. John P. Helmick, of Fairmont, held the office a few years ago.

Mrs. Holcombe has been signally honored by Auxiliary groups. She served as president of the West Virginia Auxiliary in 1940 and is a past president of the Woman's Auxiliary to the American Medical Association. She has always taken an active interest in local, state, and national Auxiliary affairs, and is just completing a term as first vice president of Southern Medicial Auxiliary.

She will be installed as president of the Southern Medical Auxiliary at the next annual meeting, which will be held in Dallas, Texas, in 1951.

POTOMAC SOCIETY OF ANESTHESIOLOGISTS MEETS

A meeting of the Potomac Society of Anesthesiologists, composed of specialists in this field practicing in Virginia, West Virginia, Maryland and the District of Columbia, was held November 27, 1950, at the Medical Society Building in Washington, D. C.

Dr. William E. Bageant, Chairman of the Section, presided at the meeting.

WRITTEN TEST, 1952, AM. BD. OPH.

Applications for the American Board of Ophthalmology's Written Test for 1952 are now being accepted by the secretary, Edwin B. Dunphy, M. D., at the Board's Executive offices, 56 Ivie Road, Cape Cottage, Maine. Applications for this test must be filed before July 1, 1951. The tests are held annually, in January, in various parts of the United States.

The Board reports that 98 examinations have already been held, resulting in the issuance of 3143 certificates. A total of 273 applications were received during the fiscal year ending April 30, 1950.

Practical examinations in 1951 are scheduled for San Francisco, March 11-16; New York City, May 31-June 5; and Chicago, October 8-13.

Dr. John H. Dunnington, of New York City, is chairman of the Board, and Dr. Derrick Vail, of Chicago, vice chairman.

AM. ACAD. OPH. AND OTOL. ELECTS FELLOWS

Three West Virginia doctors were elected fellows of the American Academy of Ophthalmology and Otolaryngology at the annual meeting held in Rochester, Minnesota, October 8-13, 1950. They are Albert C. Esposito, of Huntington; James T. Spencer, Jr., of Charleston; and John H. Trotter, of Morgantown.

Doctor Esposito was also elected a fellow of the United States Chapter of the International College of Surgeons at the annual meeting in Cleveland early in November.

RELOCATIONS

Dr. Archibald D. McCoy, of Wardensville, is serving a surgical preceptorship at Mundelein, Illinois. His home address in that city is 334 High Street.

* * * *

Dr. C. W. Holcomb, of Sutton, has moved to Grantsville, where he is associated with Dr. John S. Boling, at the Boling Clinic. He will continue the practice of general medicine and surgery in that city.

* * * *

Dr. R. Moore Dodrill, of Weston, health officer for District No. 4, has resigned his position with the state department of health in order to take a postgraduate course in radiology at the Graduate School of Medicine, University of Pennsylvania, Philadelphia.

* * * *

Dr. Harold H. Cashman, of Hopemont, has accepted appointment as superintendent and medical director of Belmont Sanatorium at St. Clairsville, Ohio. He assumed his new duties there November 1.

* * * *

Dr. Wes C. Thomas, of Huntington, has moved to Delavan, Wisconsin, where he will continue the practice of his specialty of EENT. His address there is 607 Wolworth Avenue.

* * * *

Dr. Howard M. Clemmons, of Huntington, has moved to Butte, Montana, where he will continue the practice of his specialty of Orthopedic Surgery, with offices at 129 West Park.

* * * *

Dr. J. W. Calvert, formerly of Matoaka, has successfully passed the examination given by the American Board of Dermatology and Syphilology, and has located for the practice of his speciality in Bluefield, where he has offices at 1520 Bland Street.

* * * *

Dr. Truett V. Bennett, of Elbert, has moved to Charlottesville, Virginia, where he has offices at 1505 Broad Avenue.

* * * *

Dr. H. M. Ritchey, of Harrisville, has accepted a three year residency in psychiatry at "Norways" in Indianapolis. His address there is 1836 East Tenth Street.

* * * *

Dr. F. Vivan Lilly, of Rainelle, has moved to Beaver, where he will continue in general practice.

* * * *

Dr. Ralph Frazier, who has been on the staff at Madison General Hospital, in Madison, for the past several months has moved to War, where he will engage in general practice.

* * * *

Dr. John E. Summers, who was formerly a member of the resident surgical staff of Myers Clinic Hospital, Philippi, has accepted appointment as chief of surgery at the UMW Union Hospital, in West Frankfort, Illinois.

* * * *

Dr. L. O. Spencer, of Fairmont, has moved to Milford, Connecticut, where he will continue in general practice. He has offices in that city at 97 North Street.

X-RAY SHOE FITTING MACHINES CHECKED

A check of 75 x-ray shoe fitting machines in West Virginia has been completed by the bureau of industrial hygiene of the state department of health and, according to Dr. N. H. Dyer, state director of health, only seven machines have been found which meet all the requirements and regulations set up by the state board of control. Another six of the machines did not show excessive radiation but failed to meet other requirements fixed by the board.

The survey was undertaken by the bureau as it was felt the x-ray shoe fitting machines might constitute a potential menace to the health of the public.

It was also felt that the increased use of x-ray machines in the diagnosis and treatment of diseases makes non-essential exposure of hazard to the individual.

A few machines in use in West Virginia have already been overhauled at a factory. However, it is stated in a release from the bureau of industrial hygiene that machines have been inspected on which stray radiation leakage while the operator was making a fitting at the point where it passed through the operator's legs was higher than 2,000 milli-roentgens per hour, and was higher than 2,000 milli-roentgens per hour where it passed through the operator's eyes. The limit set by regulations as being safe is 12.5 mili-roentgens per hour.

It has been found that the direct beam passing through the customer's foot on some machines has gone as high as 80 roentgens per minute. The regulations set a maximum of 12 roentgens per minute as being permissible. Machines that have already been repaired have been found to operate satisfactorily on only 7 to 8 roentgens per minute, which is well within the requirements of the regulations.

Another check on all machines is planned after repairs have been made. If specifications are met, a card certifying to this fact will be furnished for display for the information of the public.

PG COURSE IN CHEST DISEASES

A postgraduate course in recent advances of diseases of the chest, sponsored by the Council on Postgraduate Medical Education of the American College of Chest Physicians, will be held January 22-27, 1951, at the Vanderbilt University School of Medicine, Nashville, Tennessee.

The clinical, pathological, radiological, physiologic and surgical aspects of chest diseases will be presented by the members of the faculties of Southern medical schools. Tuition is $50.00 and registration is limited.

Applications should be addressed to the Council on Postgraduate Medical Education, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

CHARLESTON DOCTORS CERTIFIED

Dr. Richard N. O'Dell and Dr. Philip Preiser, of Charleston, have been certified by the American Board of Internal Medicine.

VITAL STATISTICS REPORT

A decrease in the number of births in West Virginia has occurred during the first nine months of 1950. Births total 34,933, a decrease of 2494 as compared with the same period of 1949.

Deaths decreased from 12,632 reported in 1949, to 12,498 in 1950. According to the division of vital statistics of the state department of health, deaths due to diarrhea and enteritis decreased from 194 to 92. Maternal deaths were recorded for an all-time low in West Virginia, decreasing from 32 to 26 during the first nine months of the year.

Cancer, diseases of the heart, and vascular lesions continued to increase, a trend noted for the past several years. Among communicable diseases showing an increase in the 1950 nine-month period were measles from 8 to 16, poliomyelitis from 13 to 16, and diphtheria from 3 to 7.

ACS ELECTS 1951 OFFICERS

Dr. Alton Ochsner, of New Orleans, was named president elect of the American College of Surgeons at the annual meeting held in Boston, October 26, 1950. Dr. Thomas H. Lanman, of Bostor, was elected first vice president, and Dr. Joel W. Baker, of Seattle, second vice president.

Officers will be installed at the 1951 Clinical Congress in San Francisco.

The election of Dr. Daniel C. Elkin, of Atlanta, Georgia, as a member of the Board of Regents for the term expiring in 1953 will be of interest to West Virginia doctors. It will be remembered that Doctor Elkin was attached to the staff at Ashford General Hospital (The Greenbrier) at White Sulphur Springs during World War II, and he has appeared as a guest speaker before several medical societies in this state.

DOCTOR DYER AGAIN HONORED

Dr. N. H. Dyer, State Director of Health, has been reappointed as a representative of the State and Territorial Health Officers' Association to the President's Highway Safety Conference. The appointment was made by the new president of the Association, Dr. R. L. Cleere, State Health Officer of Colorado, at the annual meeting of State and Territorial Health Officers, held in October at Washington, D. C.

Doctor Dyer has just recently been certified by the American Board of Preventive Medicine and Public Health.

WILL SHARE HONORS

Texas and West Virginia will share honors in the Southern Medical limelight during the next two years.

A Texas doctor, Dr. Curtice Rosser, of Dallas, has just been installed as president to succeed Dr. Hamilton W. McKay, of Charlotte, North Carolina. Dr. R. J. Wilkinson, of Huntington, is the president elect.

Mrs. L. S. Thompson, of Dallas, Texas, is the new president of the Southern Medical Auxiliary, and Mrs. V. Eugene Holcombe, of Charleston, is the president elect.

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OF PHILADELPHIA

MLB LICENSES 28 DOCTORS

At a meeting of the Medical Licensing Board held at the Capitol, in Charleston, October 2-4, 1950, twenty-eight doctors were licensed to practice medicine in West Virginia, eleven by direct examination, and seventeen by reciprocity with other states.

The following is the list of doctors licensed by direct examination:

Bowie, Zelda Gracielee, Lakin
Doboy, Joseph G., Iaeger
Harell, Alex, Logan
Haynes, Ralph Edwards, Freeman
Knappenberger, William Leroy, Delbarton
Marston, Edgar Lee, Pineville
Ray, Thomas Lafayette, Gary
Salisbury, Alvin B., Jr., New Haven
Stevenson, Elena Imogene, Lakin
Townsend, Clarence Vincent, Sr., Inwood
Wallace, Grover Cleveland, Beckley

The following doctors were licensed by reciprocity:

Alleback, Newton Webster, Charleston
Anders, Marcelyn Velstin, Parkersburg
Davis, Hiram Wilson, Huntington
Gish, James Robert, Bishop, Virginia
Kamons, Harold Oliver, Parkersburg
Lawton, William Edgar, Jr., Mount Hope
Lemon, Willis Edward, White Sulphur Springs
Manning, Harry Jack, Elkins
McCormack, Lawrence Ralph, Pineville
McCowen, Earl Arthur, Charleston
Parsons, John Robert, Princeton
Pittman, Robert Raikes, Cass
Pollack, Dorothy Jane, Gary
Potterfield, Thomas Garland, Charleston
Riffenburgh, Ralph Sidney, Charleston
Sibley, William Austin, Jr., Lorado
Whitaker, Charles Frederick, Jr., Parkersburg

The winter meeting of the Medical Licensing Board will be held January 8-10, 1951, at the Capitol, in Charleston, for the purpose of examinng applicants for licensure to practice in West Virginia.

DR. W. R. WILKINSON ON ICS PROGRAM

A paper on "Trichobezoar" by Dr. R. J. Wilkinson and Dr. W. R. Wilkinson, of Huntington, was presented by the latter before the 15th annual assembly of the United States Chapter of the International College of Surgeons, at Cleveland, Ohio, Wednesday afternoon, November 1, 1950. Dr. Philip Thorek, of Chicago, presided at the afternoon session.

Dr. R. J. Wilkinson, a past president of the West Virginia State Medical Association, is now first vice president of the Southern Surgical Association, and first vice president of the Southern Medical Association.

HOUSE DELEGATION REELECTED

All of the present members of the House of Representatives from West Virginia were reelected at the general election November 7, 1950, and will serve during 1951 and 1952. All are Democrats. They are as follows:

First district, Robert L. Ramsay, Follansbee; second, Harley O. Staggers, Keyser; third, Cleveland M. Bailey, Clarksburg; fourth, M. G. Burnside, Huntington; fifth, John Kee, Bluefield; and sixth, Dr. E. H. Hedrick, Beckley.

WEST VIRGINIAN ON NATIONAL SCIENCE BOARD

Dr. John W. Davis, President of West Virginia State College, at Institute, has been named by President Truman as one of the twenty-four members of the National Science Foundation Board.

According to Dr. Joseph S. Lawrence, director of the AMA Washington offices, the Foundation created by Congress has wide grants of power to promote basic research and education in mathematics, physical science, medical science, biology, engineering, etc. It will award grants, make loans, and issue scholarships, in addition to correlating public and private research, acting as a research information clearing house and maintaining a register of scientists, to be known as the National Roster of Scientific and Specialized personnel.

Congress has appropriated $225,000 for operations during the Foundation's first year. Appropriation of $15,000,000 is authorized for each subsequent year.

"NEW HOPES FOR HEARTS"

According to the American Heart, published by the American Heart and its affiliates, the slogan for the 1951 Heart Fund drive next February will be "New Hope for Hearts."

The reason assigned for selecting this hopeful keynote for the annual fund raising campaign is to highlight the scientific gains achieved in treating diseases of the heart and circulation. The slogan will be featured in campaign posters, on billboards, and in literature distributed in connection with the campaign.

48,000,000 CHRISTMAS SEALS MAILED

Local chapters of the West Virginia Tuberculosis and Health Association are mailing out 48 million Christmas Seals. Distribution started on November 20 and the sale will continue until Christmas Day. The seals have been mailed to West Virginia citizens with the request that they purchase them and thus aid in the fight against tuberculosis.

Each year during the Christmas season people all over the United States receive the seals by mail, and it has become an American tradition to use them on Christmas mail and packages, thus representing the people's fight against tuberculosis.

By the sale of the seals in West Virginia it is hoped that $190,000 may be raised to carry on the program of case-finding, health education, research, rehabilitation, cooperation, and social service.

ACS HOSPITAL STANDARDIZATION PROGRAM

At a meeting of the Regents of the American College of Surgeons, held October 21, 1950, in Chicago, continuation of the Hospital Standardization Program of the College was approved. The vote was unanimous.

Following the meeting, a spokesman for the Regents stated that the action taken does not necessarily preclude consideration of proposals for the participation of other interested agencies in this program, but does make it clear that the American College of Surgeons "has an undiminished interest in it and will consider no proposal which will not insure its continuation in the best interests of the public."

UNOFFICIAL ROSTER OF MEMBERS OF THE SENATE AND HOUSE OF DELEGATES, 1951

The 1951 session of the West Virginia Legislature will convene at the Capitol, in Charleston, at noon, Wednesday, January 10.

The official roster of the members of the Legislature will not be compiled until the names of elected members have been certified to the Secretary of State. The following is the unofficial roster of members of the Senate and House of Delegates who will serve during the 1951 session:

SENATE

District	Member
First	*Herbert Traubert (D), Follansbee William A. Hannig (R), Elm Grove
Second	*Theodore M. Bowers (R), New Martinsville John E. Carrigan (R), Moundsville
Third	*Harry E. Moats (R), Harrisville Andy Swearingen (R), Walker
Fourth	*Bartow Jones (R), Pt. Pleasant E. Ray Reed (R), Clay
Fifth	*C. H. McKown (D), Wayne Andrew R. Winters (D), Huntington
Sixth	*William Mitchell (D), Welch Glenn Taylor (D), Matewan
Seventh	*Glen Jackson (D), Logan Lloyd G. Jackson (D), Hamlin
Eighth	*John E. Amos (D), Charleston Charles M. Love, (D), Charleston
Ninth	*Dr. Ward Wylie (D), Mullens Robert C. Byrd (D), Sophia
Tenth	*W. Broughton Johnston (D), Princeton J. Lynn Swiger (D), Hinton
Eleventh	*J. Alfred Taylor, Jr. (D), Fayetteville John H. Boling (D), White Sulphur Springs
Twelfth	*Fred C. Allen (D), Marlinton Henry J. McKinley (D), Elkins
Thirteenth	*Floyd D. Boner (D), Salem Walter A. Holden (D), Salem
Fourteenth	*C. Howard Hardesty (D), Fairmont Don J. Eddy (D), Morgantown
Fifteenth	*A. L. Reed (R), Newburg Dayton R. Stemple (R), Philippi
Sixteenth	*Ralph J. Bean (D), Moorefield Clarence E. Martin, Jr. (D), Martinsburg.

(D) Democrat
(R) Republican
(*) Hold-over Senators, elected in 1948.

Democrats	23
Republicans	9
Total	32

HOUSE OF DELEGATES

County	Members
Barbour	Robert L. Hunt (D), Philippi
Berkeley	Stewart A. Wright (D), Martinsburg
Boone	E. E. White (D), Madison
Braxton	William M. Kidd (D), Sutton
Brooke	W. R. Curtis (D), Wellsburg
Cabell	Dr. Will E. Neal (R), Huntington Mike Casey (D), Huntington Carney M. Layne (D), Huntington Henry F. White (D), Huntington Ford F. Roberts (D), Milton
Calhoun	John Hamilton (D), Grantsville
Clay	Sylvester Mullins (D), Clay
Doddridge	Clay D. Hammond (R), West Union
Fayette	Hobart Booth, Jr. (D), Oak Hill Earl Prather (D), Oak Hill John G. Fox (D), Fayetteville Nell W. Walker (D), Winona
Gilmer	Paul H. Kidd (D), Glenville
Grant	D. W. Mouse (R), Petersburg
Greenbrier	Brack L. Campbell (D), Rupert Lester W. Watts (D), East Rainelle
Hampshire	W. L. Thompson (D), Romney
Hancock	David N. Thomas (R), Weirton
Hardy	James M. Miley (D), Moorefield
Harrison	Fred H. Caplan (D), Clarksburg Frank J. Maxwell, Jr. (D), Clarksburg Fred H. Scanes, Jr. (D), Clarksburg W. Guy Tetrick (D), Clarksburg
Jackson	Delmer Hutton (R), Kentuck
Jefferson	William P. C. Perry (D), Charles Town
Kanawha	Larry Wilson Andrews (D), Charleston J. Hornor Davis (D), Charleston James W. Loop (D), Charleston M. M. Maloney (D), Charleston R. D. Miller (D), Charleston Frank A. Knight (D), South Charleston Martin C. Bowles (D), South Charleston James E. Maroney (D), East Bank
Lewis	James H. Hall (R), Weston
Lincoln	George D. Williams (D), Alum Creek
Logan	D. B. Browning (D), Logan W. E. Flannery (D), Man Jerry E. Stidham (D), Holden
Marion	George W. May (R), Fairmont Fred L. Doringer (D), Fairmont Harry W. Hamilton (D), Fairmont
Marshall	Gordon W. Sammons (R), Moundsville Thomas E. Wilkison (D), Moundsville
Mason	George A. Rairden (R), Leon
McDowell	Elizabeth Drewry (D), Northfork W. L. Mills (D), Kimball Harry R. Pauley (D), Iaeger Roy A. Warden (D), War James L. Whitt (D), Welch
Mercer	O. H. Ballard (D), Princeton G. T. Johnston (D), Bluefield E. H. Martin (D), Athens
Mineral	John I. Rogers (R), Keyser
Mingo	Roy A. Chambers (D), Williamson Hiram Phillips (D), Sprigg Charles H. Ambler (D), Morgantown
Monongalia	William A. Moreland (D), Morgantown Dr. T. G. Matney (D), Peterstown
Monroe	Ward M. Dawson (R), Berkeley Springs
Morgan	O. J. Carroll (D), Summersville
Nicholas	George F. Beneke (R), Wheeling
Ohio	Joseph A. Gompers (R), Wheeling Ben E. Honecker (R), Wheeling Chester R. Hubbard (R), Wheeling
Pendleton	William McCoy (D), Franklin
Pleasants	J. C. Powell (R), St. Marys
Pocahontas	June McElwee (D), Marlinton
Preston	Richard Whetsell (R), Kingwood
Putnam	Raymond V. Humphries (R), Hurricane
Raleigh	Roy Lee Harmon (D), Beckley H. P. Meadows (D), Beckley Everett R. Shaffer (D), Beckley
Randolph	Wallace W. Barron (D), Elkins
Ritchie	Harold Zinn (R), Pullman
Roane	R. M. McCulty (R), Spencer
Summers	C. D. McCormick (D), Hinton
Taylor	Gough Ridenour (R), Grafton
Tucker	John J. Mullennex (R), Parsons
Tyler	Cecil H. Underwood (R), Sistersville
Upshur	H. Hayden Morgan (R), Adrian
Wayne	Epison A. Cole (D), Ceredo H. T. Tucker (D), Huntington
Webster	W. S. Wysong (D), Webster Springs
Wetzel	J. A. Ashcraft (R), Hundred
Wirt	H. E. Pomroy (D), Elizabeth
Wood	J. Fred Earley (D), Parkersburg W. M. Parker (R), Parkersburg Spencer K. Creel (R), Parkersburg
Wyoming	C. A. Blankenship (D), Pineville

(D) Democrat
(R) Republican

Democrats	67
Republicans	27
Total	94

A KILLER THAT CAN BE STAMPED OUT

Although cancer is second to cardiovascular disease as the cause of death, it is more important because it is more amenable to treatment. Far be it from me to decry the importance of cardiovascular disease because I am getting into that age when cardiovascular disease is of importance, but it is largely the result of a wearing out process and we are limited in our efforts to prevent and control it. Cancer, on the other hand, strikes us when we are at the height of our productivity and it is the one principal killer which we are best able to prevent and cure. It is the one killer that we can and must stamp out.—Alton Ochsner, M. D., in J. Kansas Med. Soc.

STATE DOCTORS SUCCESSFUL AT THE POLLS

Two doctors were elected members of the House of Delegates at the general election on Novembr 7. Dr. Will E. Neal, of Huntington, will be one of the five members of the House from Cabell county and Dr. T. G. Matney, of Peterstown, will represent Monroe county in the lower House. Dr. Neal is a Republican and Doctor Matney a Democrat.

Dr. Ward Wylie, of Mullens, is a hold-over in the Senate, having been reelected from the Ninth Senatorial District in 1948.

Dr. E. H. Hedrick, of Beckley, was reelected to the House of Representatives from the Six Congressional District. He was first elected to the House in 1944 and thus will be serving his fourth successive term.

Dr. Henry M. Glass, of Charleston, was elected a member of the non-partisan board of education of Kanawha county. One other member of Kanawha Medical Society, Dr. H. M. Beddow, of Charleston, is already serving as a member of the board.

DR. R. J. CONDRY HEADS HEART ASSOCIATION

Dr. R. J. Condry, of Elkins, was named president of the West Virginia Heart Association at the annual meeting in Huntington, October 26-27, 1950.

Dr. James L. Wade, of Parkersburg, was named vice president; Dr. John S. Pearson, of Huntington, secretary; and Mr. R. E. Plott, of Charleston, treasurer.

The following were elected members of the board of directors for the term ending in 1952: Drs. Paul H. Revercomb, Charleston, Cecil O. Post, Clarksburg, William Bray, Huntington, L. J. Pace, Princeton, and W. L. Claiborne, Montgomery; and Messrs. John Smallridge, Harry Brawley, and E. D. Hardman, of Charleston; Thomas F. Stafford, of Beckley; and Mr. Coberley, of Elkins.

Help Fight TB

Buy Christmas Seals

CORRESPONDENCE

VETERANS ADMINISTRATION

Regional Office
845 Fifth Avenue
Huntington, W. Va.

November 20, 1950

Mr. Charles Lively, Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia

Dear Mr. Lively:

The Veterans Administration has received information that some fee basis physicians are prescribing and using investigational drugs for treatment of Veterans Administration outpatient beneficaries. This practice is not permitted.

Investigational drugs or drug items for which new drug applications have not been made effective by the Food and Drug Administration, and therefore, not available through the regular channels of Interstate Commerce, should not be used in authorized outpatient treatment of Veterans Administration beneficaries.

Yours very truly,

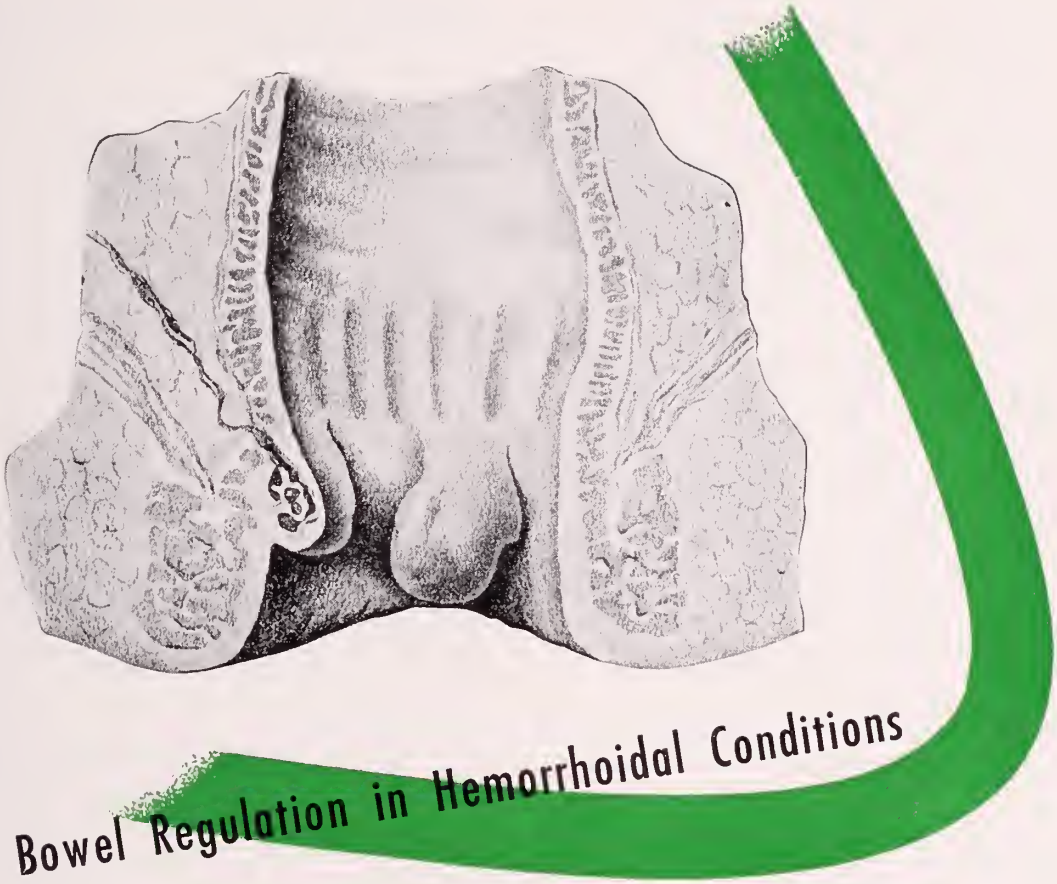
(Signed) Leo F. Steindler, M. D.,
Chief Medical Officer.

WATCH COMMUNISM, BEWARE SOCIALISM

It has become more and more evident to the laity and the profession alike that the problem of combatting nationalized medicine is but one facet of the much greater problem of opposing the conversion of this country into a socialist state. The destructive pathway along which the nationalizers of medicine—and eventually the other professions, business and industry—would lead us has many diverting byways that tend to distract attention purposely from the main issue of socialization of the country. A major bypath that lately has assumed the proportions of a superhighway in the public eye is communism.

The threat of communism is indeed real and should be thoroughly aired and completely thwarted. But it should not be overlooked that the hue and cry over the inroads of communism in our midst serve conveniently to cloak the more insidious threat of socialism. Attacking communism proved a convenient expedient for the national socialists of Germany; attacking fascism likewise proved advantageous for the communists. Here in America Nazi agents cleverly inveighed against communists, and communists, in turn, condemned Nazism as a threat to American government. Always the idea was to divert attention from their own programs.

As a people we may well take heed. While we remain aroused over the grave danger of communism to our freedom-loving manner of living, let us not permit the necessity for opposition to this repugnant foreign ideology to divert our efforts from opposition to the creeping socialism that is upon us. Its methods are much more insidious and difficult to oppose than are those of communism.—J. Florida Med. Assn.



When there is a tendency toward hemorrhoids, when hemorrhoids are present or after hemorrhoidectomy—when avoidance of straining is desired—Metamucil's smooth, demulcent action conforms to accepted bowel management.

Metamucil softens the fecal content, stimulates peristalsis by supplying plastic, bland bulk and encourages easy, gentle, regular evacuation without irritation or straining.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

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OBITUARIES

ALEXANDER M. CARR, M. D.

Dr. Alexander M Carr, 61, of Lewisburg, died suddenly November 13, 1950, in Charleston, where he was attending a meeting of the State Health Officers' Association. He became ill during a session in the offices of Dr. N. H. Dyer, state director of health, and died enroute to a hospital. Death was attributed to a heart attack.

Doctor Carr was born in Edinburgh, Scotland, and received his M. D. degree in 1918 from the University of Pennsylvania School of Medicine. He has been devoting full-time to public health work. He came to West Virginia in June, 1950, and accepted appointment as health officer for District No. 2, with headquarters at Lewisburg. The district includes Monroe, Pocahontas and Greenbrier counties. Before coming to West Virginia, he had served as Bradley County (Tennessee) health officer, with headquarters at Cleveland in that state, and is the former director of a local health service at Nashville, Tennessee.

At the time of his death, he was a member of the American Association of Industrial Physicians and Surgeons. He is survived by two sons and a daughter.

WILLIAM WEST McFARLAND, M. D.

Dr. William West McFarland, 71, of Berkeley Springs, died in a hospital in that city, October 14, 1950, where he had been acutely ill for less than a month. Death was attributed to coronary thrombosis.

Doctor McFarland was born in Pittsburgh, Pennsylvania. He received his M. D. degree from Jefferson Medical College of Philadelphia in 1902, and was licensed to practice medicine the following year. He devoted full time to public health, with offices at 519 Smithfield Street, having been located in Pittsburgh until 1947, when he retired on account of ill health.

Doctor McFarland moved to Berkeley Springs in 1947 and immediately identified himself with the War Memorial Hospital, serving on the advisory committee and as secretary of the staff. His widow survives him.

WALTON S. SHEPHERD, M. D.

Dr. Walton S. Shepherd, 77, of Charleston, died November 11, 1950, at a hospital in that city following an illness of several week's duration.

Doctor Shepherd was born at Madison Mill, Virginia, son of the late Walton Francis and Sally (Twyman) Shepherd. He received his M. D. degree from the Medical College of Virginia in 1900 and took postgraduate work in his specialty of EENT at the University of Pennsylvania and at hospitals and medical schools in Vienna, Austria.

He located at Red Sulphur Springs, and was engaged in general practice there and at Slab Fork until 1917, when he moved to Charleston, where he remained in the practice of his specialty of EENT until his death. His son, Dr. Edwin M. Shepherd, has been associated with him in the practice of his specialty of Ophthalmology since 1941.

Dr. Shepherd had served as reviewing ophthalmologist to the Department of Public Assistance since 1933, having been appointed by Gov. H. G. Kump. He was a member of Kanawha Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Besides his widow, Mrs. Lillian (Banks) Shepherd, he is survived by three sons, Dr. Edwin M.; Walton S., Jr., and J. Banks Shepherd, all of Charleston; a sister, Mrs. J. B. Whittington, of Winston-Salem, North Carolina; and a brother, Edwin Davis Shepherd, of Locustdale, Virginia.

THE ALCOHOLIC PATIENT

No one knows better than the physician, who is the confidant of the ill, of the futility of prohibition, the fruitlessness of militant temperance movements or the brutality of treating the alcoholic patient as a criminal. No one knows better than the medical profession that the most important factor in dealing with the public-health problem of alcoholism—as with most social problems—is understanding.

To this end there must be a universal awareness of the factors involved and of the peculiar nature of the disease; its importance, its causes, its insidious character and its treatment. Condemnation of the alcoholic must give way to charity in his misfortune, faith in his rehabilitation and hope for his future.—New England Journal of Medicine.

PREVENTIVE TYPE OF MEDICINE

The physician has an important role to play in the early diagnosis of cancer. His efforts should be concerned with (1) improving his own diagnostic ability, and (2) teaching his patients how to recognize cancer themselves.

Over the years, doctors in certain fields of medicine have stimulated their patients to learn how to help in their own care. This preventive type of medicine has been employed with considerable success by obstetricians in pre- and post-natal cases; by pediatricians in infectious diseases; and by phthisiologists in the treatment of tuberculosis. It is my belief that a program of education can be prepared and given to each patient by his or her doctor which will greatly increase the opportunities for early diagnosis in cancer.—Eugene P. Pendergrass, M. D., in North Carolina Medical Journal.

CHLOROPHYLL FOR HALITOSIS

In one hospital it has been found that the new chlorophyll tablets are effective in controlling odors from ulcerative colitis and cancer. Doses varied from four to ten tablets daily. It was also found that two tablets daily curbed post-operative halitosis.—R. N.

CONQUERING MALARIA

Malaria, long a health problem in the southern states, has decreased from 135,000 reported cases in 1935 to only 4,000 in 1949.—R. N.

COUNTY SOCIETIES

BARBOUR-RANDOLPH-TUCKER

Dr. E. Lyle Gage, of Bluefield, was the guest speaker at the October 19 dinner meeting of the Barbour-Randolph-Tucker Medical Society, held in the Fellowship Hall, at Philippi. Discussing "The Early Diagnosis of Brain Tumors," the speaker emphasized the symptoms taught in medical schools concerning such tumors. He outlined a program by which the general practitioner, using simple apparatus, could detect such growths.

Doctor Gage presented a number of case histories, illustrated by x-rays, ventroencelographs, and anatomical specimens. A question and answer period followed his very fine address.

At the business meeting preceding the scientific program, the president announced the appointment of a diabetes committee, composed of Drs. Semon M. Lilienfeld, of Parsons, chairman, John E. Lenox, of Philippi, and W. G. Harper, of Elkins. The committee was instructed to carry out the program outlined by the diabetes committee of the West Virginia State Medical Association.

A report of the meeting on the treatment of atomic casualties, held at Clarksburg, October 8, was presented by Dr. John E. Lenox, and Dr. Michael M. Stump reported briefly concerning a similar meeting held at Charleston on October 15. Doctor Lenox also presented a resume of the meeting on ACTH and Cortisone held October 4 in Charleston.—Donald R. Roberts, M. D., Secretary.

* * * *

FORT HENRY ACADEMY OF MEDICINE

Dr. Edward F. Bland, of Boston, physician and chief of the Cardiac Clinic and Laboratory, Massachusetts General Hospital, and clinical associate in medicine at Harvard Medcal School, presented an interesting paper on "Some Special Features of Rheumatic Heart Disease" at the October meeting of the Fort Henry Academy of Medicine, held in the auditorium of the Nurses' Residence of Wheeling Hospital. Discussion of the paper was opened by Dr. J. P. McMullen, of Wellsburg, and Dr. Warren Leslie, of Wheeling.

The meeting was attended by eighty-five members and guests.—Robert U. Drinkard, M. D., Secretary.

* * * *

GREENBRIER VALLEY

Dr. Archer A. Wilson, of Charleston, was the guest speaker at the October meeting of the Greenbrier Valley Medical Society, held at Ronceverte. The staff of the Greenbrier Valley Hospital was in charge of the meeting. Doctor Wilson's subject was "Ruptured Nucleus."

Dr. T. E. Hynson, of Charleston, director of the bureau of venereal disease control, state department of health, was the guest speaker at the November meeting of the Greenbrier Valley Medical Society, held November 8, at the Greenbrier Clinic, in White Sulphur Springs.—George L. Lemon, M. D., Secretary.

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KANAWHA

Dr. Vernon L. Peterson, of Charleston, was elected president of the Kanawha Medical Society at the regular monthly meeting held November 14, at the Daniel Boone Hotel, in Charleston. Dr. Howard A. Swart was elected vice president, and John C. Condry was named a member of the Board of Censors.

Dr. Robert L. Brown, of Charleston, was elected to membership in the Society.

Dr. John McKittrick, a member of the medical faculty of Harvard Medical School, was the guest speaker on the scientific program which preceded the business meeting. His subject was, "Trans-metatarsal Resection in the Diabetic."—Robert C. Bock, M. D., Secretary.

* * * *

MARION

Dr. Paul Gregg, of Pittsburgh, chief of cardiology of the Children's Hospital in that city, was the guest speaker at a meeting of the Marion County Medical Society, held October 31, in Fairmont.

Doctor Gregg presented an excellent basic discussion of ACTH and Cortisone, recounting experiences of his group with the substances in the Pittsburgh area.

At a business meeting following the scientific program, the following doctors were elected to membership in the Society: Delbert Cleo Smith, Kenneth D. Bailey and M. D. Phelps, Jr., all of Fairmont.—George T. Evans, M. D., Secretary.

MERCER

A record attendance of members of the Mercer County Medical Society was set at the regular monthly dinner meeting held October 16, at Pete's Grill, in Bluefield. Dr. George Cooper, Associate Professor of Radiology at the University of Virginia, was the guest speaker. His subject was "Limitations of Roentgenological Diagnosis." Fifty-nine members of the Society answered the roll call.

At the business meeting held preceding the scientific program, the Society reaffirmed its approval of the blood bank program of the Bluefield Chapter of the American Red Cross.

Dr. E. Lyle Gage and Dr. W. H. St. Clair discussed socialized medicine, and Dr. W. A. Shafer submitted a report on the "Medical Aspects of Atomic Weapons."—Frank J. Holroyd, M. D. Secretary.

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McDOWELL

Dr. Frank J. Holroyd, president elect of the West Virginia State Medical Association, was the guest speaker at the regular monthly meeting of the McDowell County Medical Society held November 8, at Welch. He discussed interestingly the problems confronting the State Medical Association at the present time, particularly the need for a four-year school of medicine and dentistry.

At the business meeting following the scientific program, the following officers were elected for 1951:

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Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting February 5, March 5.
Surgical Anatomy & Clinical Surgery, Two Weeks, starting February 19, March 19.
Surgery of Colon & Rectum, One Week, starting March 5.
Basic Principles in General Surgery, Two Weeks, starting April 2.
Gallbladder Surgery, Ten Hours, starting April 23.
Fractures and Traumatic Surgery, Two Weeks, starting March 19.

GYNECOLOGY—Intensive Course, Two Weeks, starting February 19.
Vaginal Approach to Pelvic Surgery, One Week, starting March 5.

OBSTETRICS—Intensive Course, Two Weeks, starting March 5.

MEDICINE—Intensive General Course, Two Weeks, starting April 23.
Gastro-enterology, Two Weeks, starting May 14.
Gastroscopy, Two Weeks, starting March 5.
Electrocardiography & Heart Disease, Two Weeks, starting March 19.

PEDIATRICS—Intensive Course, Two Weeks, starting April 2.
Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting April 16.
Cystoscopy, Ten Day Practical Course, every two weeks.

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MONONGALIA

Dr. Chester Beall, of Pittsburgh, presented an interesting paper on "The Rh Factor in Obstetrics" at the regular monthly meeting of the Monongalia County Medical Society, held November 7, in Morgantown.—Maynard P. Pride, M. D., Secretary.

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WOMAN'S AUXILIARY

HARRISON

At the regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society, held November 2, at the Waldo Hotel, in Clarksburg, Mr. Charles Lively, of Charleston, executive secretary of the West Virginia State Medical Association, discussed "Trends in Medical Legislation." The speaker stressed particularly the great need for a four-year school of medicine and dentistry in this state.

Mrs. R. K. Hanifan, the president, presided at the meeting, which was attended by 35 members. The invocation was given by Mrs. J. Keith Pickens, and hostesses for the evening were Mrs. O. W. Ladwig and Mrs. D. P. Cruikshank.—Mrs. E. Burl Randolph, Secretary.

* * * *

MARION

Mr. W. C. Handlan, of Fairmont, Publicity Director for the Monongahela Power, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Marion County Medical Society, held October 31 at the Fairmont Hotel. His subject was, "Legislative Government."

The speaker presented an interesting comparison of two kinds of government. First, a free and independ-

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ent government by and for the people, such as we have known and enjoyed in the past; and, second, a government which has infiltrating tendencies of a socialistic and destructive nature, seeking to control the fields of industry and education.

Mrs. George T. Evans, of Fairmont, president of the Auxiliary presided at the meeting, which was attended by fourteen members—Mrs. Rupert W. Powell, Secretary.

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MONONGALIA

A Woman's Auxiliary to the Monongalia County Medical Society was organized at a meeting held October 25, at the Morgantown County Club. Mrs. John F. McCuskey, of Clarksburg, president elect of the State Auxiliary, was present and assisted with the organization.

Mrs. Lucien Strawn was named president of the new group, and other officers were elected as follows: First vice president, Mrs. George A. Curry; secretary, Mrs. H. A. Shaffer; and treasurer, Mrs. Maynard Pride.

The meeting was attended by twenty-three charter members of the new auxiliary group.—Mrs. H. A. Shaffer, Secretary.

* * * *

PRESTON

Officers of the new Woman's Auxiliary to the Preston County Medical Society were elected at a recent meeting as follows: President, Mrs. T. S. McIntire, Kingwood; president elect, Mrs. Jerome Arnett, Rowlesburg; and secretary-treasurer, Mrs. D. R. Davis, Kingwood.—Mrs. D. R. Davis, Secretary.

* * * *

RALEIGH

Mr. Harry R. May, of Beckley, president of the Raleigh County Cancer Society, was the guest speaker at a luncheon of the Woman's Auxiliary to the Raleigh County Medical Society, held October 16, at the Beckley Hotel, in Beckley. The speaker discussed plans to establish an information center in Beckley, and requested the aid of the Auxiliary in this important work.

One of the main Auxiliary projects of the year will be to help obtain two hundred pints of blood each month in cooperation with the Red Cross. Mrs. C. A. Smith has been named chairman for this drive. The blood will be used for patients in the Raleigh General Hospital, Pinecrest Sanitarium, and the new Veterans Administration Hospital in Beckley.

Mrs. L. E. Shrewsbury sang several selections following the business meeting, being accompanied by Miss Beverly Watts.

Mrs. R. G. Broaddus, the president, presided at the meeting, which was attended by twenty-eight members and guests.—Mrs. G. F. Fordham, Secretary.

"I've brought you a Red Cross nurse," said the Doctor.

"Take her away," said the peevish patient, "I want one who is blonde and cheerful."—Baribou Rotary.

BOOK REVIEWS

TECHNIQUES IN BRITISH SURGERY—Edited by Rodney Maingot, FRCS. Illustrated. Pp. 734, with 473 figures. Philadelphia and London: W. B. Saunders Company. 1950. Price $15.00.

This book was written by twenty nine leading British surgeons. It presents in concise form a description of the techniques of a selected group of operations of general surgery. The subject matter covers such widely divergent fields as surgery of the spinal cord and hypospadias, but mostly deals with abdominal surgery. It presents not only technique but also indications for operation and special attention to pre and post operative care.

The descriptions, for the most part, are well organized and clear. British spelling and phraseology are evident throughout the book. It is well illustrated with charts, diagrams, radiographs, line drawings and half tones.

The writers definitely present the point of view of the British surgeon although on most controversial subjects they freely refer to the work of American and other surgeons. There are exceptions. For example, the use of morphine in head injuries is advocated when needed for restlessness and no mention is made of the fact that many surgeons oppose its use.

A few of the interesting differences in therapy are: (1) The treatment of mesenteric thrombosis by conservative measures; (2) the treatment of stricture of the lower end of the esophagus by Heller's extramucous esophagocardiomyotomy; and (3) the paravertebral injection of 10% phenol to accomplish destruction of the lumbar sympathetic ganglia.

A whole chapter is devoted to aseptic intestinal anastomoses even though it seems to us that the indications for this type of reconstruction of the intestine almost disappeared with the advent of antibiotic therapy. Recent developments in surgery of the hand are not mentioned. The chapter by Millin on radical retropubic surgery of the prostate is an excellent presentation by this pioneer of the expanding use of the retropubic approach for prostatic disease.

The British surgeons are noted for their knowledge of the basic sciences and for their practical application of the fundamentals. This book gives evidence of such fact. Many ingenious devices to facilitate technique are described. It is a book from which the well trained surgeon will obtain many new ideas. It is not to be considered as a textbook on surgery.—Hu C. Myers, M. D.

* * * *

PATHOLOGIC PHYSIOLOGY: Mechanisms of Disease—Edited by William A. Sodemon, M. D., F. A. C. P., the William Henderson Professor of the Prevention of Tropical and Semi-Tropical Diseases, Tulane University of Louisiana School of Medicine, and Senior Visiting Physician, Charity Hospital of Louisiana. Pp. 808, with 146 figures and 30 tables. Philadelphia and London: W. B. Saunders Company. 1950. Price $11.50.

This is a textbook, intended to bridge the gap between the texts on physiology and medicine "by pre-

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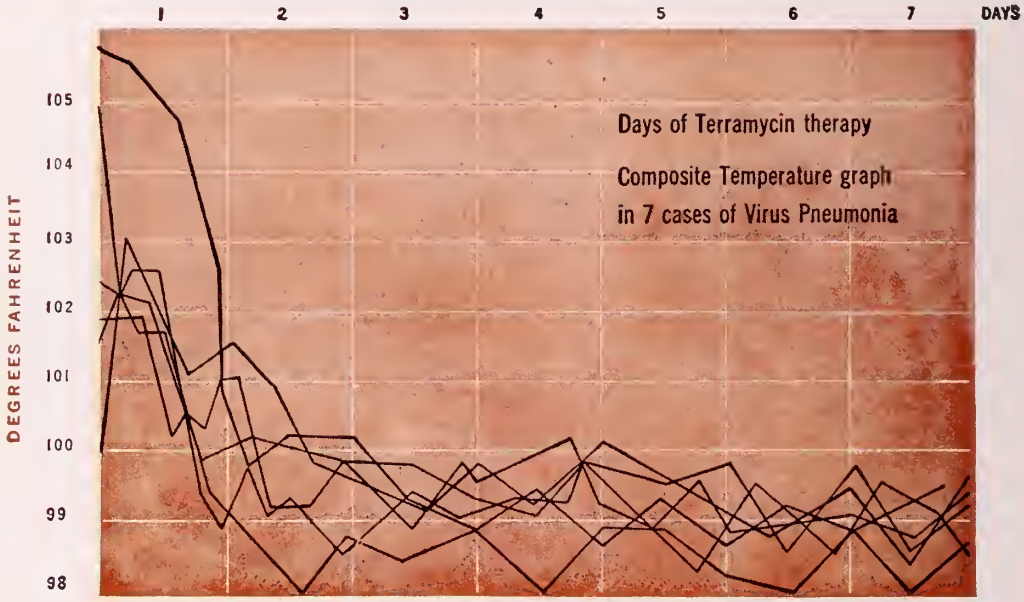

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Melcher, G. W.; Gibson, C. D.; Rose, H. M., and Kneeland, Y.: J. A. M. A. 143:1303 (Aug. 12) 1950

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1. *Blake, F. G.; Friou, G. J., and Wagner, R. R.: Yale J. Biol. and Med. 22:495 (July) 1950.*
2. *Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.*

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senting a clinical picture of disease seen as physiologic dysfunction."

Twenty-five authors participated in its writing, giving the usual disjointed effect of a symposium, with no unified viewpoint. It seems to this reviewer that the modern tendency to turn out textbooks which are essentially a series of monographs by specialists is to be deplored. Multiple authorship may be desirable in a reference work, but it makes a text difficult to study. It also results, in the present case, in a certain amount of imbalance between subjects. An entire fourth of the book is devoted to the circulatory system, and only 32 pages to nutrition. There is no section on neurology, and psychosomatic relationships are not discussed.

Even within the sections coverage is spotty; ventricular dilatation and hypertrophy get only two pages; iron deficiency half a page. The preface indicates that this is all according to plan, but one wonders why it was planned that way (couldn't they get a neurologist to write a chapter?).

On the credit side, the book contains a lot of information, which on the whole is clearly presented. The discussion of the electrocardiogram is especially well presented. In fact, the whole section on the circulatory system is very good indeed. There is also an excellent chapter on water and salt metabolism.

The publishers are to be congratulated on a beautiful job of bookmaking—clear and attractive typography, excellent figures, and a handsome binding.—David W. Northup, Ph. D.

EYES AND INDUSTRY—By Hedwig S. Kuhn, M. D., Hammond, Indiana. Pp. 378, with 151 illustrations. The C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, Mo. Price $8.50.

The author has collected in this book quite a comprehensive statistical and medical report of literature on file with the Joint Committee of Industrial Ophthalmology. To this literature she has added her own observations and opinions.

The first four chapters pertaining to visual testing, skills, standards and corrective programs are idealistic in content, but do form a definite program of progress toward which the safety engineer and the ophthalmologist may work.

Chapter five has been contributed by Albert C. Snell, M. D., in his own inimitable style. This chapter covers Eye Injuries Caused by Solid Bodies in minute detail and should be required reading by all ophthalmologists doing industrial work.

Chapter six concerns radiation injuries and is an excellent summary of all data published to date concerning this serious and painful injury.

Chapter seven deals with Chemical Eye Injuries and here the author has allowed her enthusiasm over a new drug to bias her opinion on this important and frequent injury. The implication in this chapter is that the use of Hydrosulphosol has the uncanny magic of rapidly curing any and all types of chemical burns. On page 231 strict adherence to the basic principle of denuding is advised as the first step, and yet under the procedure outlined on page 232 this important step

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is notably missing. Chemical burns, after all, do have individual characteristics and should be more individualized than the author has indicated.

Eye protection and illumination are well covered in chapters eight and nine to form an excellent hand book for control of these factors.

The author is to be commended on her treatment of the problem of the blind in industry. It certainly is a step forward to correct Dr. Meyer Wiener's statement that "more has been written about the problem of the blind and less done about it than any other subject."

Under the headings of Miscellaneous and Appendix there is a wealth of information touching all of the subjects of interest to the industrial ophthalmologist.

Of particular interest in this book is the complete list of references on every subject, compiled at no small effort. The possessor of this book practically has a Cummulative Index at his hand insofar as industrial ophthalmology is concerned. A complete index adds to the value of the book.—Ralph S. McLaughlin, M. D.

* * * *

POSTGRADUATE GASTROENTEROLOGY—Edited by Henry L. Backus, M. D., Professor of Gastroenterology, University of Pennsylvania Graduate School of Medicine, Philadelphia. Pp. 670, with 258 figures. Philadelphia and London: W. B. Saunders Company. 1950. Price $10.00.

A publication of the course in Gastroenterology given by the American College of Physicians during the week of December 6-11, 1948. Most of the presentations are in the nature of symposia, with three periods of case presentation and clinical conferences included. The volume represents a very comprehensive review of this limited field, with special attention to unsettled problems and recent advances.—Clark K. Sleeth, M. D.

* * * *

PLASTIC AND RECONSTRUCTIVE SURGERY: A Manual of Management—By Ferris Smith, M. D., F. A. C. S., Consultant in Plastic Surgery, Bladgett Memorial Hospital, Grand Rapids, Michigan. Pp. 895, with illustrations. Philadelphia and London: W. B. Saunders Company. 1950. Price $15.00.

This new manual, written by a master in the field of plastic surgery, is a ready reference book for the management of cutaneous deformities. The author has packed it with concise but complete coverage of all fields of plastic and reconstructive surgery. It is profusely illustrated with photographs, drawings and diagrams.

The book is well planned, starting with general considerations of fundamental surgical procedures, and, continuing in orderly fashion, it discusses procedures for each region of the body, such as the face, scalp, etc. As a manual of management, there are no detailed step-by-step descriptions of operations, but an extensive bibliography is appended for any who desire more details.

Poor procedures described elsewhere are fearlessly denounced by the author, and the reasons for their failure explained on physiologic and anatomic grounds. Thus, if a recommended facial reconstruction leaves a

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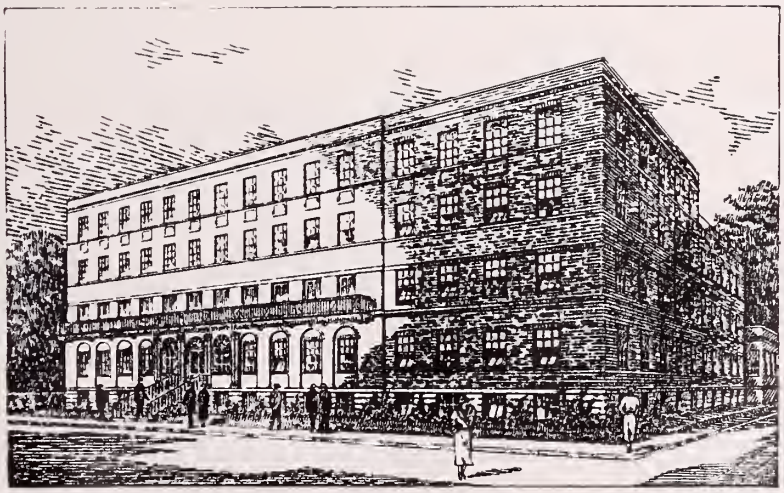

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flap of skin with inadequate blood supply, the reader is clearly and adequately forewarned.

Even in more common lesions, as fracture of the nasal bones and thermal burns, the outline of treatment is clearly stated and explained on physiologic principles. This book is a worthy addition to the library of any physician contemplating the treatment of cases involving plastic procedures.—Henry G. Storrs, M. D.

The disturbances of senescence which baffle geriatrics today are as obscure in their origins as were the infectional and nutritional diseases of the nineteenth century.—Irving J. Wolman, M. D., in Geriatrics.

LOST VISION BY CROSS-EYE

The amount of lost vision caused by cross-eye is in direct ratio to the duration of the squint. Correction of this defect of the eyes can be attained by glasses, eye exercises or surgery. Patient, parent, and physician must be aware that only early and accurate diagnosis is most urgent to obtain satisfactory results. Treatment should be instituted as soon as the child shows any signs of turning of the eyes.—Lewis V. Kogut, M. D., in Ohio St. Med. J.

If you don't think the laws are being enforced, park near a fire hydrant.—West Virginia State Bar News.

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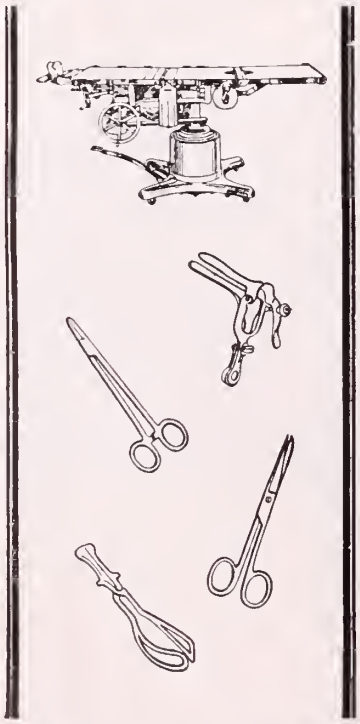
REFERENCES



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AMA CLINICAL SESSION AT CLEVELAND

The American Medical Association estimates that 5,000 physicians from all parts of the United States will attend the fourth Clinical Session at Cleveland, December 5-8. A like number of guests will probably be present.

Dr. Walter E. Vest, of Huntington, and Dr. George F. Evans, of Clarksburg, will represent the West Virginia State Medical Association as delegates to the House of Delegates. Many other West Virginia doctors are planning to attend the meeting.

The annual Clinical Session is designed primarily for the family doctor or general practitioner. The sessions are always held during the month of December.

According to Dr. George F. Lull, AMA Secretary and General Manager, clinical discussions will be presented by leading physicians and will cover the common diseases seen by the general practitioner in his practice. The program is being arranged to inform him, through oral and visual presentations, of the latest techniques in diagnosis and treatment.

All scientific sessions will be held in the Cleveland Public Auditorium, and scientific and technical exhibits will be set up there. Sessions of the House of Delegates will be held at the Hotel Statler. A daily feature on the scientific program will be color telecasts of surgical procedures and demonstrations.

Among the general topics discussed at the scientific sessions will be cancer, heart and blood vessel diseases, diabetes, diseases of children, dermatology and syphilology, gastro-intestinal diseases, surgery dealing with injuries, obstetrics, neurology and psychiatry, anesthesia, and poliomyelitis. More than 80 physicians will appear on the scientific program.

MORTALITY AT ALL-TIME LOW

It now appears likely that the annual mortality rate will drop to a new low in 1950. The death rate for the first nine months of the year among the Industrial policyholders of the Metropolitan Life Insurance Company was 6.4 per 1,000, as compared with the previous minimum of 6.5 recorded in the corresponding period of 1949.

The females have done better than the males. The death rate for white females is 2 per cent below that for the January-September period of last year, whereas the rate for white males shows no change. Interestingly enough, the declines in each sex are concentrated at the younger ages, with minor decreases recorded in midlife and later.

The favorable record for the current year reflects the absence of any serious epidemics as well as the effectiveness of present methods of controlling the infectious diseases. Thus, the four principal communicable diseases of childhood have been all but eliminated as causes of death among these insured. Measles, scarlet fever, whooping cough, and diphtheria together recorded a death rate of only 0.7 per 100,000; the comparable rate a year ago was 1.1.

The mortality from acute poliomyelitis up through September, although not a new low, was only one half

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that for the same period of last year, the respective death rates being 0.7 and 1.5 per 100,000 policyholders. It is pertinent to note that for the first nine months there were 21,537 cases of the disease reported in the general population of the country this year, as compared with 33,119 in the like part of 1949.

Rapid gains continue to be made in the control of the respiratory diseases. The death rate from pneumonia and influenza set a new minimum in the January to September period, the rate this year—18.2 per 100,000—being 12 per cent below that a year ago. Tuberculosis showed the same relative drop, the death rate reaching an all-time low level of 22.0 per 100,000 for the first nine months of the year.

Minimum mortality is also in evidence for syphilis, appendicitis, gastritis, and the complications of pregnancy and childbirth. The mortality from each of these diseases has been reduced at least one half in the past decade. The record for the diseases incidental to childbearing is particularly noteworthy. The puerperal mortality rate in this insurance experience has decreased two thirds in the past decade, despite a marked increase in the birth rate. It is estimated that, on the basis of live births, the maternal death rate among the insured women is now less than 1 per 1,000.

So far in 1950 the mortality from the principal degenerative diseases has remained at approximately the same level as in 1949. The increases in the death rates from cancer and diabetes in the current year have been balanced by the decrease in deaths from the cardiovascular-renal diseases. The combined figures for these diseases affect materially the general mortality rate, inasmuch as they account for more than 70 per cent of the total.—Statistical Bulletin, Metropolitan Life Insurance Company.

ANTIPOLIO ELEMENT IN HUMAN MILK

Recently Dr. Albert B. Sabin, of the Children's Hospital Research Foundation of Cincinnati, reported a most interesting discovery which may perhaps be the key to the solution of a terrible problem. What Doctor Sabin has found is a substance in the milk of about 75 per cent of mothers and in the milk of an occasional cow, which will protect a baby from polio anywhere from one month to 340 days after birth.

This discovery can explain why in those parts of the world in which the mothers nurse their babies for three or four years, small children do not get paralyzed.

When the substance from the milk is mixed with the virus of polio and injected into the brains of mice, none of the animals get paralyzed. Everyone will watch with great interest for further reports on this substance in milk—GP.

THERE IS A PROBLEM

I am fully aware of the fact that it usually takes a cataclysm of some sort to jar the average man out of his self-complacency. But this time we cannot afford to wait for Jove's thunderbolt. The time has come when we can no longer narcotize ourselves with the I-see-no-problem-therefore-there-is-no-problem formula. There is a very definite medical problem, and the sooner we

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recognize that fact and accept the responsibility for its solution the less danger there will be of the Federal Government's doing it for us.—Eugene A. Ockuly, M. D., in Bulletin Toledo Academy of Medicine.

INTO THE FIRE?

In any country, lower income groups are "for" any governmental scheme or party which prevails during an era of seemingly improved financial welfare for them, whether it is stable or not. They are reluctant to "make a change" while they are "better off than before" and their fundamental means of subsistence are "adequate."

Upper income groups admit they don't get as good medical care as before; they know the difference between good and bad. Asked why they don't go to a private doctor, they say, "We're paying for it, we'll take what we're paying for." Such is a trait of human personality. Tickle it in the pocketbook and the individual jumps. Where? Sometimes right into the fire.—Rocky Mt. Med J.

PROGRESS NEEDED IN HUMAN RELATIONS

Medicine a century ago must have been a discouraging business, as discouraging perhaps as were difficulties encountered by the transcontinental pioneers in their covered wagons. It will do us all, and the public, good to review the progress that has been made in medical science in the last century. Maybe, next year, after our celebration is over and when we eat our Thanksgiving dinners, we'll feel like sending up a little extra "thanks" that we are privileged to live in the world—at least the medical world—as it is today.

Only one sour note creeps into our thinking as we contemplate a celebration to mark the advances of the scientific world, and to most of us the thought must occur that we wish the same progress could have been made in the world of human relations.—Lee Forrest Hill, M. D., in Bulletin, Folk County (Iowa) Medical Society.

NO EXTRA CHARGE FOR JAMA IN 1951

The Journal of the American Medical Association will be sent without extra charge to all members of the American Medical Association who pay the regular dues of $25.00 for 1951. The subscription price is $12.00 per annum and members have been required to pay for the Journal during 1950.

A special bulletin is being mailed December 1 by the West Virginia State Medical Association to all members. Both state and AMA dues of $15.00 and $25.00, respectively, are payable January 1. In addition, there will be a special state assessment of $10.00 for 1951, and this assessment will be collected and remitted, with annual dues, by component society secretaries and treasurers.

The House of Delegates, at the annual meeting at White Sulphur Springs last July, directed that the special assessment be collected for 1951 from each member of the State Medical Association.

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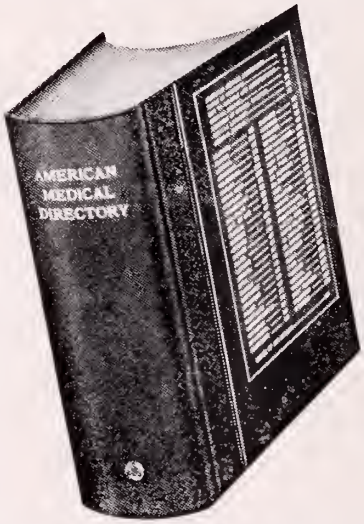

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INDEX TO VOLUME XLVI

WEST VIRGINIA MEDICAL JOURNAL — 1950

A

A Step Toward Dictatorship—A. B. Bowyer, M. D. Oct., 301
Acute Anterior Poliomyelitis—James A. Heckman, M. D. Apr. 94
Alarm Reaction, The—John M. Brewster, Capt. (MC) USN Dec., 337
Alcohol, Retrobulbar Injection of—Charles M. Polan, M. D. Oct. 299
Alcoholism, Treatment of With Antabuse—V. E. Mace, M. D. Dec., 343
Allergic Manifestations of the Eye—Charles T. St. Clair, Jr., M. D., and Ben W. Bird, M. D. Feb., 39
Anderson, Thomas A. Jr., Lt. (j. g.) (MC) USN, and Brewster, John M. Capt. (MC) USN—Pyranisamine Maleate, Its Use in Treatment of the Common Cold in Young Children Feb., 36
Anesthesia, The Newer Developments in—L. H. Mousel, M. D. Mar., 60
Antabuse, Treatment of Alcoholism With—V. E. Mace, M. D. Dec., 343
Atomic Age, Medical Care In the—Harold C. Lueth, M. D. Feb. 31

B

Barbiturate Poisoning (Case Report)—Arthur Roy Fleming, M. D. Aug., 218
Baxter, Leone—Medical Freedom and How to Keep It Oct., 293
Benign Prostatic Hypertrophy, The Pathologic Physiology of—A. Kyle Bush, M. D. Aug., 219
Bird, Ben W., M. D., and St. Clair, Charles T., Jr., M. D.—Allergic Manifestations of the Eye. Feb., 39
Bituminous Coal Miners, Pulmonary Function Studies in—Harley L. Motley, M. D. Jan., 8
Bladder, A Case of Exstrophy of the—G. G. Irwin, M. D., and Morris H. O'Dell, M. D. May, 118
Bond, George F., M. D, Rural Medical Facilities Nov., 321
Bowyer, A. B., M. D.—A Step Toward Dictatorship Oct., 301
Brewster, John M. Capt. (MC) USN, and Anderson, Thomas A., Jr., Lt. (j. g.) (MC) USN—Pyranisamine Maleate, Its Use in Treatment of the Common Cold in Young Cihldren Feb., 36
Brewster, John M., Capt. (MC) USN—The Alarm Reaction Dec., 337
British Medical Situation, The—E. B. Randolph, M. D. June, 153
Broadening Front Against State Socialism, The—Clem Whitaker. Oct., 296
Buff, I. E., M. D.—The Use of a Cholinergic Agent in Diagnosing Borderline Cardiac Disease Jan., 1
Bush, A. Kyle, M. D.—The Pathologic Physiology of Benign Prostatic Hypertrophy Aug., 213

C

Calcinosis Interstitialis Circumscripta (Case Report)—Mitchell S. Madison, M. D. Apr., 88
Cameron, Charles S., M. D.—Toward Effective Cancer Control Apr., 101
Cancer Control, Toward Effective—Charles S. Cameron, M. D. Apr., 101
Cancer of the Stomach—John E. Summers, M. D. Dec., 345
Cardiac Disease, The Use of Cholinergic Agent in Diagnosing Borderline—I. E. Buff, M. D. Jan., 1
Cataract Extraction, 6-0 Chromatized Gut in Wound Closure After Sept., 251
Cholinergic Agent in Diagnosing Borderline Cardiac Disease, The Use of a—I. E. Buff, M. D. Jan., 1
Chromatized Gut in Wound Closure After Cataract Extraction, 6-0—F. Bruce Fralick, M. D. Sept., 251
Common Cold in Young Children, Use of Pyranisamine Maleate in Treatment of—John M. Brewster, Capt. (MC) USN, and Thomas A. Anderson, Jr., Lt. (j. g.) (MC) USN Feb., 36
M. D. Aug. 219
Conservative Renal Surgery—Edgar W. Kirby, Jr., M. D. Aug., 219
Cook, J. R., M. D., Yates, W. K., M. D., and Swann, W. C., M. D.—The Treatment of Occlusive Peripheral Arterial Disease by Intra-Arterial Histamine June, 149

D

DeQuervain's Disease in Mother and Daughter—H. A. Swart, M. D. May, 123
Diagnosis in Congenital Heart Disease—William C. Stewart, M. D. June, 135
Dictatorship, A Step Toward—A. B. Bowyer, M. D. Oct., 301
Double Zipper Sponge Rubber Collar For Iron Lung—E. Bennette Henson, M. D. June, 148
Dyer, N. H., M. D. Rural Health Centers Nov. 328
Dysphagia Following Dilation of Esophageal Carcinoma, Prolonged Relief From—Edward B. Mewborne, M. D., and Porter P. Vinson, M. D. Dec., 348

E

Epilepsy, The Psychiatric Aspects of—James B. Funkhouser, M. D. Oct., 304
Esophageal Carcinoma, Prolonged Relief From Dysphagia Following Dilation of—Edward B. Mewborne, M. D., and Porter P. Vinson, M. D. Dec., 348
Exstrophy of the Bladder, A Case of—G. G. Irwin, M. D., and Morris H. O'Dell, M. D. May, 118
Eye, Allergic Manifestations of the—Charles T. St. Clair, Jr., M. D. and Ben W. Bird, M. D. Feb. 39

F

Fleming, Arthur Ray, M. D.—Barbiturate Poisoning Aug., 218
Fralick, F. Bruce, M. D.—Chromatized Gut in Wound Closure After Cataract Extraction Sept., 251
Funkhouser, James B., M. D.—The Psychiatric Aspects of Epilepsy Oct., 304

G

Goodhand, Charles L., M. D.—Management of Occiput Posterior Postion Apr., 85

H

Hatton, Don V., M. D.—A Study of the Q-T Interval in the Adult Male Dec., 349
Health Centers, Rural—N. H. Dyer, M. D. Nov., 328
Health, Progress and Problems in National—Leonard A. Scheele, M. D. July, 169
Health Survey in Roane County, Report of Rural—Gertrude Humphreys Nov., 317
Heart Disease, Congenital, Diagnosis in—William C. Stewart, M. D. June, 135
Heckman, James A., M. D.—Acute Anterior Poliomyelitis Apr., 94
Hematuria, The Significance of—R. M. LeComte, M. D. Jan. 4
Henson, E. Bennette, M. D.—Double Zipper Sponge Rubber Collar for Iron Lung June, 148
Hernia Into the Foramen of Winslow (Case Report)—J. G. Rennie, M. D. July, 179
Highlights of Psychiatry: Past, Present, and the Outlook for the Future—G. D. Johnson, M. D. Sept. 248
Humphreys, Gertrude—Report of Rural Health Survey in Roane County Nov., 317

I

Iron Lung, Double Zipper Sponge Rubber Collar For—E. Bennette Henson, M. D. June, 148
Irwin, G. G., M. D., and O'Dell, Morris H., M. D.—A Case of Exstrophy of the Bladder May, 118
Irvin, G. E., M. D.—Loeffler's Syndrome, Transitory Pulmonary Infiltration and Eosinophilia (Case Report) Sept., 256

J

Johnson, G. D., M. D.—Highlights of Psychiatry: Past, Present, and the Outlook for the Future Sept., 248

K

Kirby, Edgar W., Jr., M. D.—Conservative Renal Surgery Aug., 219

L

Lewless, J. J., M. D.—Parathion Poisoning May, 125
LeComte, R. M., M. D.—The Significance of Hematuria Jan., 4
Loeffler's Syndrome, Transitory Pulmonary Infiltration and Eosinophilia (Case Report)—G. E. Irvin, M. D. Sept., 256
Lueth, Harold C., M. D.—Medical Care in the Atomic Age Feb., 31

M

Mace, V. E., M. D.—Treatment of Alcoholism with Antabuse ... Dec., 343
Madison, Mitchell, S., M. D.—Calcinois Interstitialis Circumscripta ... Apr., 88
Management of Occiput Posterior Position—Charles L. Goodhand, M. D. ... Apr., 85
Mayers, Harold, and John T. Morrison, M. D.—Principles Guiding the U. M. W. A. Welfare and Retirement Fund: Medical, Health and Hospital Section ... Apr., 97
Medical Care in the Atomic Age—Harold C. Lueth, M. D. ... Feb., 31
Medical Education and Practice in Peru, Some Observations on—Edward J. Van Liere, M. D. ... Mar., 68
Medical Freedom and How to Keep It—Leone Baxter ... Oct., 293
Mewborne, Edward B., M. D., and Vinson, Porter P., M. D.—Prolonged Relief from Dysphagia Following Dilation of Esophageal Carcinoma ... Dec., 348
Milestones in Public Health—Thomas Parran, M. D. July, 174
Morrison, John T., M. D., and Harold Mayers—Principles Guiding the U. M. W. A. Welfare and Retirement Fund: Medical, Health and Hospital Section ... Apr., 97
Motley, Hurley L., M. D.—Pulmonary Function Studies in Bituminous Coal Miners ... Jan., 8
Mousel, L. H., M. D.—The Newer Developments in Anesthesia ... Mar., 60
Mulholland, Henry B., M. D.—Problems of Rural Medical Care ... Nov., 326
Myocardial Infarction, Pitressin and—F. R. Whittelsey, M. D. ... Feb., 38

N

Newer Developments in Anesthesia, The—L. H. Mousel, M. D. ... Mar., 60

O

Occiput Posterior Position, Management of—Charles L. Goodhand, M. D. ... Apr., 85
Occlusive Peripheral Arterial Disease, The Treatment of by Intra-arterial Histamine—W. C. Swann, M. D., J. R. Cook, M. D., and W. K. Yates, M. D. ... June, 149
O'Dell, Morris H., M. D.—A Case of Exstrophy of the Bladder ... May, 118
Ophthalmology, Plastic Surgery in—Byron Smith, M. D. ... Mar., 63
Owen, Thelma V., M. D. and Stemmermann, M. G., M. D.—Prognosis of Schizophrenia ... Aug., 224

P

Prolonged Relief from Dysphagia Following Dilation of Esophageal Carcinoma—Edward B. Mewborne, M. D., and Porter P. Vinson, M. D. ... Dec., 348
Parran, Thomas, M. D.—Milestones in Public Health ... July, 174
Parathion Poisoning—J. J. Lawless, M. D. ... May, 125
Pathologic Physiology of Benign Prostatic Hypertrophy, The—A. Kyle Bush, M. D. ... Aug., 213
Physiology at West Virginia University School of Medicine, The Teaching of—Edward J. Van Liere, M. D. ... May, 120
Pitressin and Myocardial Infarction—F. R. Whittlesey, M. D. ... Feb., 38
Plastic Surgery in Ophthalmology—Byron Smith, M. D. ... Mar., 63
Polan, Charles M., M. D.—Retrobulbar Injection of Alcohol ... Oct., 299
Poliomyelitis, Acute Anterior—James A. Heckman, M. D. ... Apr., 94
Principles Guiding the U.M.W.A. Welfare and Retirement Fund: Medical, Health, and Hospital Section—Harold Mayers, and John T. Morrison, M. D., ... Apr., 97
Problems of Rural Medical Care—H. B. Mulholland, M. D. ... Nov., 326
Prognosis of Schizophrenia—M. G. Stemmermann, M. D., and Thelma V. Owen, M. D. ... Aug., 224
Progress and Problems in National Health—Leonard A. Scheele, M. D. ... July, 169
Prostatic Hypertrophy, The Pathologic Physiology of Benign—A. Kyle Bush, M. D. ... Aug., 219
Psychiatric Aspects of Epilepsy—James B. Funkhouser, M. D. ... Oct., 304
Psychiatry, Hightlights of: Past, Present, and the Outlook for the Future—G. D. Johnson, M. D. ... Sept., 248
Public Health, Milestones in—Thomas Parran, M. D. ... July, 174
Pulmonary Function Studies in Bituminous Coal Miners—Hurley L. Motley, M. D. ... Jan., 8
Pyranisamine Maleate, Its Use in Treatment of the Common Cold in Young Children—John M. Brewster, Capt. (MC) USN, and Thomas A. Anderson, Jr., Lt. (j.g.) (MC) USN ... Feb., 36

Q

Q-T Interval in the Adult Male, A Study of the—Don V. Hatton, M. D. ... Dec., 349

R

Randolph, E. B., M. D.—The British Medical Situation ... June, 153
Renal Surgery, Conservative—Edgar W. Kirby, Jr., M. D. ... Aug., 219
Rennie, J. G., M. D.—Hernia Into the Foramen of Winslow ... July, 179
Report of Rural Health Survey in Roane County—Gertrude Humphreys ... Nov., 317
Retrobulbar Injection of Alcohol—Charles M. Polan, M. D. ... Oct., 299
Rural Health Centers—N. H. Dyer, M. D. ... Nov., 328
Rural Health Survey in Roane County, Report of—Gertrude Humphreys ... Nov., 317
Rural Medical Care, Problems of—H. B. Mulholland, M. D. ... Nov., 326
Rural Medical Facilities—George F. Bond, M. D. ... Nov., 321

S

Scheele, Leonard A., M. D.—Progress and Problems in National Health ... July, 169
Schizophrenia, Prognosis of—M. G. Stemmermann, M. D., and Thelma V. Owen, M. D. ... Aug., 224
Significance of Hematuria, The—R. M. LeComte, M. D. ... Jan., 4
Smith, Byron, M. D.—Plastic Surgery in Ophthalmology ... Mar., 63
Some Observations on Medical Education and Practice in Peru—Edward J. Van Liere, M. D. ... Mar., 68
State Socialism, The Broadening Front Against—Clem Whitaker ... Oct., 296
St. Clair, Charles T., Jr., M. D. and Bird, Ben W., M. D.—Allergic Manifestations of the Eye ... Feb., 39
Stemmermann, M. G., M. D. and Owen, Thelma V., M. D.—Prognosis of Schizophrenia ... Aug., 224
Stewart, William C., M. D.—Diagnosis in Congenital Heart Disease ... June, 135
Stomach, Cancer of the—John E. Summers, M. D. Dec., 345
Study of the Q-T Interval in the Adult Male—Don V. Hatton, M. D. ... Dec., 349
Summers, John E., M. D.—Thrombophlebitis in the Lower Extremity and Its Sequelae ... May, 115
Summers, John E., M. D.—Cancer of the Stomach Dec., 345
Swann, W. C., M. D., J. R. Cook, M. D., and W. K. Yates, M. D.—The Treatment of Occlusive Peripheral Arterial Disease by Intra-arterial Histamine ... June, 149
Swart, H. A., M. D.—DeQuervain's Disease in Mother and Daughter ... May, 123

T

Teaching of Physiology at West Virginia University, The—Edward J. Van Liere, M. D. ... May, 120
The Alarm Reaction—John M. Brewster, M. D., Capt. (MC) USN ... Dec., 337
Thrombophlebitis in the Lower Extremity and Its Sequelae—John E. Summers, M. D. ... May, 115
Toward Effective Cancer Control—Charles S. Cameron, M. D. ... Apr., 101
Treatment of Alcoholism with Antabuse—V. E. Mace, M. D. ... Dec., 343
Treatment of Occlusive Peripheral Arterial Disease by Intra-arterial Histamine, The—W. C. Swann, M. D., J. R. Cook, M. D., and W. K. Yates, M. D. ... June, 149

U

U.M.W.A. Welfare and Retirement Fund: Medical, Health, and Hospital Section, Principles Guiding the—John T. Morrison, M. D. and Harold Mayers Apr., 97
Uterine Bleeding—R. J. Wilkinson, M. D. ... Mar., 55

V

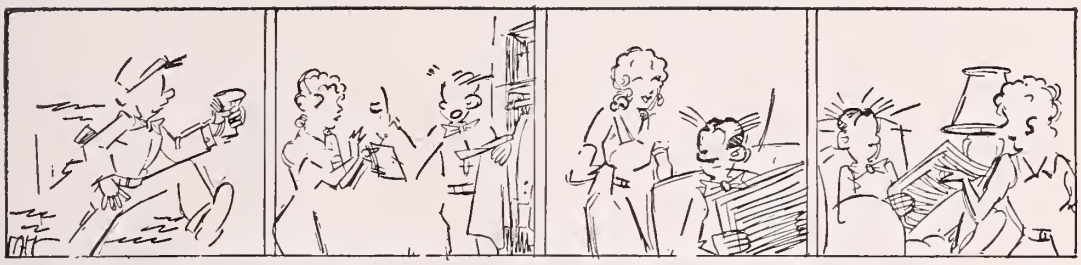
Van Liere, Edward J., M. D.—Some Observations on Medical Education and Practice in Peru ... Mar., 68
Van Liere, Edward J., M. D.—The Teaching of Physiology at West Virginia University School of Medicine ... May, 120
Vinson, Porter P., M. D., and Mewborne, Edward B., M. D.—Prolonged Relief from Dysphagia Following Dilation of Esophageal Carcinoma ... Dec., 348

W

Watkins, Charles E., M. D.—Without Fear and Trembling (President's Annual Address) ... Sept., 245
Whitaker, Clem—The Broadening Front Against State Socialism ... Oct., 296
Without Fear and Trembling (President's Annual Address)—Charles E. Watkins, M. D. ... Sept., 245
Whittlesey, F. R., M. D.—Pitressin and Myocardial Infarction ... Feb., 38
Wilkinson, R. J., M. D.—Uterine Bleeding ... Mar., 55

Y

Yates, W. K., M. D., Cook, J. R., M. D., and Swann, W. C., M. D.—The Treatment of Occlusive Peripheral Arterial Disease by Intra-arterial Histamine ... June, 149



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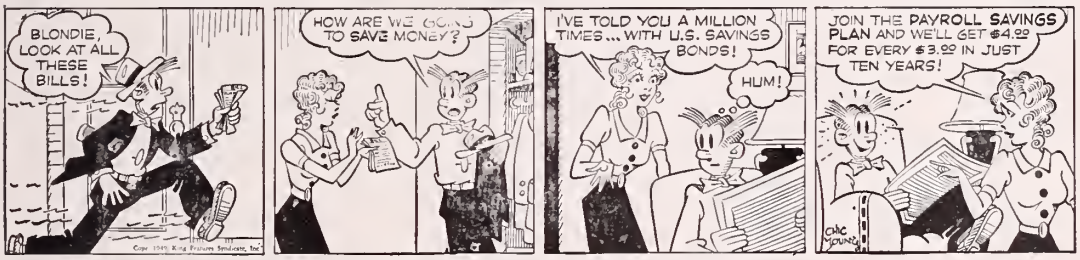

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CONTENTS

The Alarm Reaction: Its Relation to Origin and Antihistamine Therapy of the Common Cold
By John M. Brewster, Captain (MC), USN

Treatment of Alcoholism with Antabuse (Tetraethylthiuramdisulfide)
By V. E. Mace, M. D.

Cancer of the Stomach
By John E. Summers, M. D.

Prolonged Relief from Dysphagia Following Dilation of Esophageal Carcinoma
By Edward B. Mewborne, M. D., and Porter P. Vinson, M. D.

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By Don V. Hatton, M. D.

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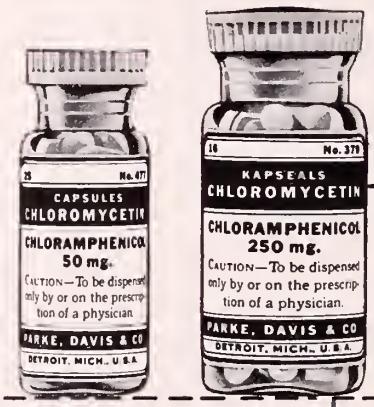

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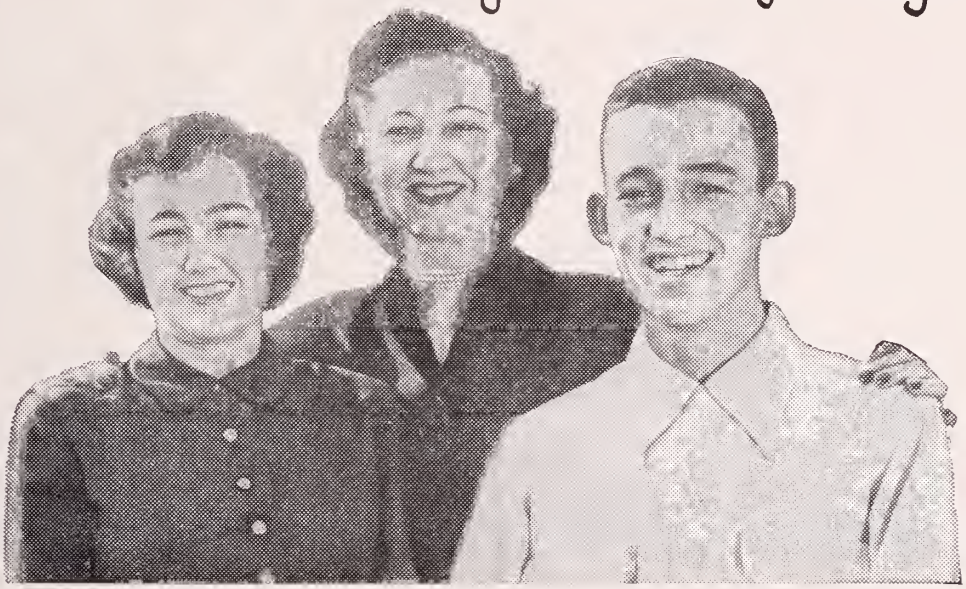

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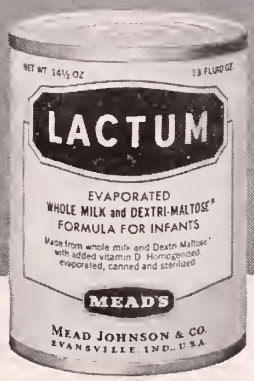

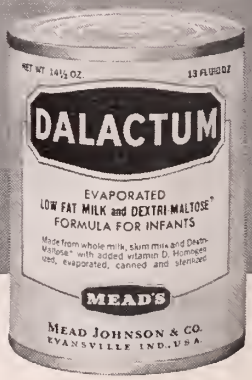

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